YOUR GROUP INSURANCE PLAN BENEFITS

PEAK MANUFACTURING

CLASS 0001

DENTAL BUY-UP, STD, VISION ACCESS, VOLUNTARY LTD

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

We, The Guardian, certify that the employee named below is entitled to the insurance benefits provided by The Guardian described in this certificate, provided the eligibility and effective date requirements of the plan are satisfied.

Group Policy No.	Certificate No.	Effective Date
Issued To		

This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above Plan or under any other Plan providing similar or identical benefits issued to the Planholder by The Guardian.

Stuart J Shaw
Vice President, Risk Mgt. & Chief Actuary

CGP-3-R-STK-90-3 B110.0023

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GENERAL PROVISIONS

As used in this booklet:

"Accident and health" means any dental, dismemberment, hospital, long term disability, major medical, out-of-network point-of-service, prescription drug, surgical, vision care or weekly loss-of-time insurance provided by this *plan.*

"Covered person" means an *employee* or a dependent insured by this *plan.*

"Employer" means the *employer* who purchased this *plan.*

"Our," "The Guardian," "us" and "we" mean The Guardian Life Insurance Company of America.

"Plan" means the Guardian *plan* of group insurance purchased by your *employer.*

"You" and "your" mean an *employee* insured by this *plan.*

CGP-3-R-GENPRO-90 B160.0002

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of The Guardian, has the authority to act for us to: (a) determine whether any contract, plan or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or plan, or any requirements of The Guardian; (c) bind us by any statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

CGP-3-R-LOA-90 B160.0004

Incontestability

This *plan* is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this *plan* shall be used in contesting the validity of his insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his lifetime.

If this *plan* replaces a plan your *employer* had with another insurer, we may rescind the *employer's plan* based on misrepresentations made by the *employer* or an *employee* in a signed application for up to two years from the effective date of this *plan.*

CGP-3-R-INCY-90 B160.0003

Examination and Autopsy

We have the right to have a *doctor* of our choice examine the person for whom a claim is being made under this *plan* as often as we feel necessary. And we have the right to have an autopsy performed in the case of death, where allowed by law. We'll pay for all such examinations and autopsies.

CGP-3-R-EA-90 B160.0006

Accident and Health Claims Provisions

Your right to make a claim for any *accident and health* benefits provided by this *plan,* is governed as follows:

Notice You must send us written notice of an *injury* or *sickness* for which a claim is being made within 20 days of the date the *injury* occurs or the *sickness* starts. This notice should include your name and *plan* number. If the claim is being made for one of your *covered dependents,* his or her name should also be noted.

Proof of Loss We'll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the *injury* or *sickness* that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, you must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, you must send us written proof of loss within 90 days of the date we request it. For any other loss, you must send us written proof within 90 days of the loss.

Late Notice of Proof We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.

Payment of Benefits We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We'll pay all other *accident and health* benefits to which you're entitled as soon as we receive written proof of loss.

We pay all *accident and health* benefits to you, if you're living. If you're not living, we have the right to pay all *accident and health* benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

When you file proof of loss, you may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can't tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this *plan* to such provider.

Limitations of Actions You can't bring a legal action against this *plan* until 60 days from the date you file proof of loss. And you can't bring legal action against this *plan* after three years from the date you file proof of loss.

Workers' Compensation The *accident and health* benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CGP-3-R-AHC-90 B160.0005

Coordination Between Continuation Sections

A covered person may be eligible to continue his group health benefits under this plan's "Federal Continuation Rights" section and under other continuation sections of this plan at the same time. If he chooses to continue his group health benefits under more than one section, the continuations: (a) start at the same time; (b) run concurrently; and (c) end independently, on their own terms.

A covered person covered under more than one of this plan's continuation sections: (a) will not be entitled to duplicate benefits; and (b) will not be subject to the premium requirements of more than one section at the same time.

CGP-3-R-COC-87 B240.0044

An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to the employer's plan. The employee must contact his employer to find out if: (a) the employer is subject to the "Federal Continuation Rights" section, and therefore; (b) the section applies to the employee.

CGP-3-R-NCC-87 B240.0064

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice

This section applies only to any dental, out-of-network point-of-service medical, major medical, prescription drug or vision coverages which are part of this plan. In this section, these coverages are referred to as "group health benefits."

This section does not apply to any coverages which apply to loss of life, or to loss of income due to disability. These coverages can not be continued under this section.

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this plan as: (a) an active, covered employee; (b) the spouse of an active covered employee; or (c) the dependent child of an active, covered employee. A child born to, or adopted by, the covered employee during a continuation period is also a qualified continuee. Any other person who becomes covered under this plan during a continuation provided by this section is not a qualified continuee.

Under federal law, "marriage" means a legal union between one man and one woman as husband and wife, and "spouse" refers to a person of the opposite sex who is a husband or wife. This plan will allow an active, covered employee's spouse of the same sex and that spouse's dependent children to continue group health benefits under this provision only when: (a) the employer consents; and (b) that employee elects such continuation coverage.

Conversion

Continuing the group health benefits does not stop a qualified continuee from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this plan in force at the time the continuation ends.

If Your Group Health Benefits End

If your group health benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if you were not terminated due to gross misconduct.

The continuation: (a) may cover you or any other qualified continuee; and (b) is subject to "When Continuation Ends".

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to your termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, a qualified continuee must give your employer written proof of Social Security's determination of the disabled qualified continuee's disability as described in "The Qualified Continuee's Responsibilities". If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your employer within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation is subject to "When Continuation Ends".

An additional 50% of the total premium charge also may be required from all qualified continuees who are members of the disabled qualified continuee's family by your employer during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

CGP-3-R-COBRA-96-1 B235.0272

If You Die While Insured

If you die while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

CGP-3-R-COBRA-96-2 B235.0075

If Your Marriage Ends

If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

If a Dependent Child Loses Eligibility

If a dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this plan, other than your coverage ending, he or she may elect to continue such benefits. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends".

Concurrent Continuations

If a dependent elects to continue his or her group health benefits due to your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period, the dependent becomes eligible for 36 months of continuation due to any of the reasons stated above.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule

If you become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after your later termination of employment or reduction of work hours, will be the longer of: (a) 18 months (29 months if there is a disability extension) from your termination of employment or reduction of work hours; or (b) 36 months from the date of your earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify your employer, in writing, of: (a) your legal divorce or legal separation from your spouse; (b) the loss of dependent eligibility, as defined in this plan, of an insured dependent child; (c) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (d) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such continuation; and (e) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Notice of an event that would qualify a person for continuation under this section must be given to your employer by a qualified continuee within 60 days of the latest of: (a) the date on which an event that would qualify a person for continuation under this section occurs; (b) the date on which the qualified continuee loses (or would lose) coverage under this plan as a result of the event; or (c) the date the qualified continuee is informed of the responsibility to provide notice to your employer and this plan's procedures for providing such notice.

Notice of a disability determinaton must be given to your employer by a qualified continuee within 60 days of the latest of: (a) the date of the Social Security Administration determination; (b) the date of the event that would qualify a person for continuation; (c) the date the qualified continuee loses or would lose coverage; or (d) the date the qualified continuee is informed of the responsibility to provide notice to your employer and this plan's procedures for providing such notice. But such notice must be given before the end of the first 18 months of continuation coverage.

CGP-3-R-COBRA-96-3 B235.0178

Your Employer's Responsibilities

A qualified continuee must be notified, in writing, of: (a) his or her right to continue this plan's group health benefits; (b) the premium he or she must pay to continue such benefits; and (c) the times and manner in which such payments must be made.

Your employer must give notice of the following qualifying events to the plan administrator within 30 days of the event: (a) your death; (b) termination of employment (other than for gross misconduct) or reduction in hours of employment; (c) Medicare entitlement; or (d) if you are a retired employee, a bankruptcy proceeding under Title 11 of the United States Code with respect to the employer. Upon receipt of notice of a qualifying event from your employer or from a qualified continuee, the plan administrator must notify a qualified continuee of the right to continue this plan's group health benefits no later than 14 days after receipt of notice.

If your employer is also the plan administrator, in the case of a qualifying event for which an employer must give notice to a plan administrator, your employer must provide notice to a qualified continuee of the right to continue this plan's group health benefits within 44 days of the qualifying event.

If your employer determines that an individual is not eligible for continued group health benefits under this plan, they must notify the individual with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee's continued group health benefits under this plan are cancelled prior to the maximum continuation period, your employer must notify the qualified continuee as soon as practical following determination that the continued group health benefits shall terminate.

Your Employer's Liability

Your employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, us, if: (a) he or she fails to remit a qualified continuee's timely premium payment to us on time, thereby causing the qualified continuee's continued group health benefits to end; or (b) he or she fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give your employer written notice that he or she elects to continue. This must be done by the later of: (a) 60 days from the date a qualified continuee receives notice of his or her continuation rights from your employer as described above; or (b) the date coverage would otherwise end. And the qualified continuee must pay his or her first premium in a timely manner.

The subsequent premiums must be paid to your employer, by the qualified continuee, in advance, at the times and in the manner specified by your employer. No further notice of when premiums are due will be given.

The premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the group plan on a regular basis. It includes any amount that would have been paid by your employer. Except as explained in "Extra Continuation for Disabled Qualified Continuees", an additional charge of two percent of the total premium charge may also be required by your employer.

If the qualified continuee fails to give your employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date. If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the premium that must be paid; unless your employer notifies the qualified continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to your employer.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

(1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

(2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

(3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

(4) the date the employer ceases to provide any group health plan to any employee;

(5) the end of the period for which the last premium payment is made;

(6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or

(7) the date, after the date of election, he or she becomes entitled to Medicare.

CGP-3-R-COBRA-96-4 B235.0198

Uniformed Services Continuation Rights

If you enter or return from military service, you may have special rights under this *plan* as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If your group health benefits under this *plan* would otherwise end because you enter into active military service, this *plan* will allow you, or your dependents, to continue such coverage in accord with the provisions of USERRA. As used here, "group health benefits" means any dental, out-of-network point-of service medical, major medical, prescription drug or vision coverages which are part of this *plan.*

Coverage under this plan may be continued while you are in the military for up to a maximum period of 24 months beginning on the date of absence from work. Continued coverage will end if you fail to return to work in a timely manner after military service ends as provided under USERRA. You should contact your employer for details about this continuation provision including required premium payments.

CGP-3-R-COBRA-96-4 B235.0195

YOUR CONTINUATION RIGHTS

Your and your insured dependents' right to continue coverage under this plan is governed as follows.

When You and Your Dependents Can Continue

If You Leave The Group

If you leave the group covered by this plan, you will remain insured for all group benefits provided by this plan, except for group term life insurance, until the earlier of:

- the end of a 31 day period which starts on the date your group benefits would otherwise end; or
- the date you become eligible for similar benefits.

Your then insured dependents will also remain insured for such group benefits for the same time period you remain insured. But your dependents must remain eligible dependents, as defined in this plan.

If You Are Laid Off

If you are involuntarily laid off from your employment for reasons other than a plant closing, you can elect to continue any hospital, surgical or major medical expense benefits for which you are insured under this plan. You may not continue any other coverages. If you choose, this continuation may also cover your then insured dependents.

You and your insured dependents can continue such benefits until the earliest of the following:

- the end of a 39 week period which starts on the date your group benefits would otherwise end;
- the date you or your insured dependents become eligible for similar group benefits under another group plan;
- the expiration of a period not longer than the period during which you were most recently insured under the group plan;
- the date the group plan ends, or is amended to end benefits for the class of employees to which you belong;
- the end of the period for which the last premium payment was made; or
- with respect to each of your insured dependents, the date he is no longer an eligible dependent, as defined in this plan.

If Your Plant Closes

If you are involuntarily laid off from your employment due to a plant closing or a covered partial plant closing as defined by Massachusetts state law, you may continue any hospital, surgical or major medical expense benefits for which you are insured under this plan. You may not continue any other coverages. If you choose, this continuation may also cover your then insured dependents.

You and your insured dependents can continue such benefits until the earliest of the following:

- the date you or your insured dependents become eligible under another plan;

- the end of the period for which the last premium payment was made;
- with respect to each of your insured dependents, the date he is no longer an eligible dependent, as defined in this plan; or
- 90 days from the date this continuation started.

If Your Marriage Ends

Unless the court judgment so provides to the contrary, in case of divorce or legal separation, your insured former spouse can elect to continue any hospital, surgical, major medical or dental coverages for which he is insured by this plan. The continuation will cover your former spouse and any of your then insured dependent children whose group benefits would otherwise end.

Your former spouse or dependent child can continue his benefits until the earliest of the following:

- the end of the period specified in the court judgment;
- the date of remarriage of either you or your former spouse, unless the court judgment provides that, subject to payment of premiums, your former spouse has the right to continue to receive coverage after you remarry.
- the date the group plan ends, or is amended to end benefits for the class of employees to which you belong;
- the end of the period for which the last premium payment was made; or
- the date he is no longer an eligible dependent, as defined in this plan, for reasons other than the marriage ending.

If You Die While Insured

If you die while insured, your then insured surviving spouse and insured dependent children may elect to continue some of this plan's group benefits for up to 39 weeks as follows.

The continuation period: (a) will be limited to any hospital, surgical, or major medical coverages provided by this plan; (b) will be subject to a monthly premium, as explained in "The Premium" below; and (c) will end on the first of the following:

- the end of a 39 week period which starts on the date the dependent's group benefits would otherwise end;
- the date the dependent becomes eligible for similar group health benefits under another group plan;
- the expiration of a period not longer than the period during which the dependent was most recently insured under the group plan;
- the date the group plan ends, or is amended to end benefits for the class of employees to which you belong;
- the end of the period for which the last premium payment was made; or
- the date a dependent is no longer an eligible dependent, as defined in this plan.

The Employer's Responsibilities

The employer must notify a laid-off employee, a surviving dependent or a divorced spouse, in writing, of:

- the right to continue specified group benefits;
- the monthly premium, if any, which must be paid to continue the group benefits; and
- the time and manner in which the premium payments must be made.

The employer must notify such person within seven days of the event which would otherwise cause his coverage to end.

Election of Continuation

With the exception of a divorced spouse, in order to continue this plan's benefits, as described above, the covered person must give the employer written notice of his election to continue, and he must pay the first month's premium. This must be done within 31 days of the date he receives the notice of continuation rights from the employer. If the covered person fails to do this, he waives his continuation rights.

The Premium

The monthly premium for continued coverage will be the total rate which would have been charged had the covered person stayed insured by the group plan on a regular basis.

If you continue upon leaving the group or losing your employment due to a total or partial plant closing, the monthly premium must be paid by you and the employer in the shares in which it was paid prior to your leaving the group or the plant closing.

If you continue upon involuntary lay off, you must pay the total monthly premium amount.

With respect to a surviving dependent, the total monthly premium amount must be paid by the dependent.

With respect to your divorced or separated former spouse, you must pay the total monthly premium amount.

All premium payments required of a covered person must be paid to the employer at the times and in the manner specified by the employer. Failure to pay any required premiums results in the termination of the covered person's continued group benefits.

The Employer's Liability

The employer is liable to the same extent as, and in place of, us, if: (a) he fails to notify the covered person of his continuation rights on time, as described above; or (b) he fails to remit a covered person's timely premium payment to us on time, thereby causing the covered person's continued group benefits to end.

Multiple Continuations

You or your insured dependents may be eligible to continue group benefits under more than one of the above sections at the same time. If you or your insured dependent elect to continue under more than one section, or continuation is automatically provided, the continuations will be provided as follows:

If a covered person is eligible for the first 31 day continuation described in "If You Leave The Group," this continuation precedes any other continuations for which he may be eligible.

If a covered person is eligible for, and elects to continue up to 39 weeks, as described in "If You Are Laid Off," this continuation runs subsequent to any other continuations for which he may be eligible.

Conversion If you remarry and your former spouse's continued group health benefits end, your former spouse can convert to an individual health policy. And at the end of any other continuation provided under this provision, conversion rights, if any, to which you or your insured dependents may be entitled, will be available. Read "Converting This Group Health Insurance" to find out if conversion is allowed under this plan, and how it works.

CGP-3-R-CC-MA-91-3 B240.0119

ELIGIBILITY FOR DISABILITY COVERAGE

B329.0002

Employee Coverage

Eligible Employees To be eligible for employee coverage, you must be an active *full-time employee.* And you must belong to a class of *employees* covered by this *plan.*

Other Conditions You must:

(a) be legally working in the United States.

(b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:

(i) your *employer's* place of business;

(ii) some place where your *employer's* business requires you to travel; or

(iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

Note: If you are working outside the United States on a temporary assignment and you meet all other conditions of eligibility, you will be covered by this *plan,* provided that: you are on an assignment, not exceeding one year, in a country or region that is not under a travel warning issued by the US Department of State. Coverage may be available when you are: (1) on a longer temporary assignment; or (2) assigned in a region that is under a travel warning; however, coverage must be approved by us in writing.

If you must pay all or part of the cost of employee coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we also ask for *proof* that you're insurable. And you won't be covered until we approve that *proof* in writing.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. Other parts of this coverage explain if and when we require *proof.* You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

If your active *full-time* service ends before you meet any *proof of insurability* requirements that apply to you, you'll still have to meet those requirements if you're later re-employed.

CGP-3-EC-90-1.0 B329.0152

When Your Coverage Starts Employee benefits that don't require *proof* that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12:01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your occupation on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you are so capable and are working your regular number of hours.

Sometimes, the effective date shown on the sticker or in the endorsement is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this *plan* replaced.

CGP-3-EC-90-2.0 B264.0690

Delayed Effective Date For Disability Coverage

With respect to this *plan's* disability insurance, if an *employee* is not actively at work on a *full-time* basis on the date his or her coverage is scheduled to start, due to *sickness* or *injury,* we'll postpone coverage for an otherwise covered loss due to that condition. We'll postpone such coverage until he or she completes 10 consecutive days of active *full-time* service without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date the *employee* returns to active *full-time* service.

CGP-3-DEF-97 B329.0103

When Your Coverage Ends

Your short term disability coverage ends on the date your active full-time service ends for any reason.

It also ends on the date you stop being a member of a class of *employees* eligible for insurance under this *plan,* or when this *plan* ends for all *employees.* And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

It ends on the date you are no longer working in the United States, unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning issued by the US Department of State; or (2) for which we have agreed, in writing, to provide coverage.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

However, if you are disabled, as defined by this *plan* when your active *full-time* service ends, coverage remains in force during: (a) the elimination period, subject to premium payment, if (i) the disability is not excluded under the *plan;* and (ii) benefits are not excluded due to application of this *plan's* pre-existing condition provision; and (b) the period for which benefits are payable under this *plan.*

CGP-3-EC-90-3.0 B329.0178

When Your Coverage Ends

Your long term disability coverage ends on the date your active *full-time* service ends for any reason.

It also ends on the date you stop being a member of a class of *employees* eligible for insurance under this *plan,* or when this *plan* ends for all *employees.* And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

It ends on the date you are no longer working in the United States, unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning issued by the US Department of State; or (2) for which was have agreed, in writing, to provide coverage.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

However, if you are disabled, as defined by this *plan* when your active *full-time* service ends, coverage remains in force during: (a) the elimination period, subject to premium payment, if (i) the disability is not excluded under the *plan;* and (ii) benefits are not excluded due to application of this *plan's* pre-existing condition provision; and (b) the period for which benefits are payable under this *plan.*

CGP-3-EC-90-3.0 B329.0175

Your Right To Continue Group Short and Long Term Disability During A Family Leave Of Absence

Important Notice

This section may not apply. You must contact your *employer* to find out if your *employer* must allow for a leave of absence under federal law. In that case the section applies.

Continuation of Short Term And Long Term Disability Coverage

Your Short Term Disability and Long term Disability coverage may be continued at your employer's option. You must contact your employer to find out if you may continue this coverage.

If Your Group Coverage Would End

Group Short Term Disability and Long Term Disability coverage may normally end for an *employee* because he or she ceases work due to an approved leave of absence. But, the *employee* may continue his or her group coverage if the leave of absence has been granted: (a) to allow the *employee* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the *employee's* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the *employee* is on active duty(or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The *employee* will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends

Coverage may continue until the earliest of the following:

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan.*
- The end of the period for which the premium has been paid.

Definitions

As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee.*

- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

SHORT TERM DISABILITY HIGHLIGHTS

This page provides a quick guide to some of the plan features about which people most often want to know. But it's not a complete description of your short term disability plan. Read the following pages carefully for a complete explanation of what we pay, limit, and exclude.

CGP-3-STD05-HL B335.0587

Elimination Period

For disability due to injury . . . . . none

For disability due to sickness . . . . . 7 days

CGP-3-STD05-HL B335.0588

Maximum Payment Period

For disability due to injury . . . . . 13 weeks

For disability due to sickness . . . . . 13 weeks

Payments for a pre-existing condition will be limited to a maximum of 2 weeks.

CGP-3-STD05-HL B335.0590

Benefit Percent

. . . . . 60%

CGP-3-STD05-HL B335.0592

Maximum Weekly Benefit

. . . . . $750.00

CGP-3-STD05-HL B335.0598

SHORT TERM DISABILITY INCOME INSURANCE

This insurance replaces part of your income if you become disabled due to sickness or injury.

We decide: (a) if you are eligible for this insurance; (b) if you meet the requirements for benefits to be paid; and (c) what benefits are to be paid by this plan. We also interpret how this plan is to be administered. What we pay and the terms for payment are explained below.

All terms in *italics* are defined terms with special meanings. Their definitions are shown at the end of this section. Other terms are defined where they are used.

Claim Provisions

Your Duties If you become *disabled* due to *sickness* or *injury* while insured by this *plan,* you must:

(a) Give notice of claim as soon as possible after the date of your *injury* or the start of your *sickness.* Prompt notice will permit us to start disability management services.

(b) Give a complete account of the details of your *sickness* or *injury.* This will include: (i) the cause of your *disability,* if known; (ii) a description of your *sickness* or the accident that caused your *injury;* and (iii) a list of all *doctors,* hospitals, or other facilities where you have been treated for the cause of your *disability.*

(c) Allow release of medical and/or income data needed to assess your claim.

(d) Give periodic medical updates as required by this *plan.*

(e) Take part in any medical, financial or vocational assessment as required by this *plan.*

(f) Apply for other income benefits to which you may be entitled.

(g) Promptly report to us the receipt or denial of such other income benefits. And, appeal any denials to the extent possible.

(h) Promptly report to us changes in your personal status. This includes: (i) change of address or phone number; (ii) changes in how your *disability* affects your daily living; and (iii) changes in your level of social, volunteer or business activities.

(i) If we overpay benefits, promptly report and repay any amount overpaid.

(j) If you are working while *disabled,* promptly report to us the amount of your income from such work.

(k) Give us proof of your earnings for the period prior to your *disability* and while you are *disabled.*

The term "disability management services" means medical and vocational analyses and services. The goal of these services is to maximize your potential to return to gainful work. Gainful work means work for which you are, or may become, qualified by: (a) training; (b) education; or (c) experience. Such work must also be consistent with the level of your *insured earnings.*

Notice You must give written notice of your intent to file a claim under this *plan* as described in this certificate's "Accident and Health Claims Provisions."

You will need to provide the information listed below:

(a) Your full name, address, phone number, social security number, and group plan number.

(b) Your last day at work, number of hours worked, and your *own job.*

(c) Your employer contact and phone number.

(d) The nature of your *disability,* and whether or not it is work-related.

(e) Your *doctor's* name, address, and phone number.

For details, you can contact the *plan sponsor* or call Guardian at 1-800-268-2525.

Proof Of Loss You can obtain a claim form to file proof of loss from the *plan sponsor.* This form requires data from you, the *plan sponsor,* and the *doctor(s)* treating you for your *sickness* or *injury.* Proof of loss must be given to us within the time stated in this certificate's "Accident and Health Claims Provisions." If you do not receive a claim form within 15 days, you should send us written proof of loss without waiting for the form.

We require the items listed below as proof of loss:

(a) Proof of the limits on your ability to perform your *own job,* starting on the date you first became *disabled.* This proof is required from all *doctors* who have treated you for the cause of your *disability.*

(b) Proof that you have applied for all other sources of income to which you may be entitled, that may affect your payment from this *plan.*

(c) Proof of receipt of other income that may affect your payment from this *plan.*

(d) Your signed authorization for release of medical and/or financial data by the sources of such data.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Short Term Disability Claims Department
P.O. Box 26160
Lehigh Valley, PA 18002-6160

How Payments Start

To start getting payments from this *plan,* you must meet all of the conditions listed below:

(a) You must: (i) become *disabled* while insured by this *plan;* and (ii) remain *disabled* and insured for this *plan's elimination period.*

(b) You must be: (i) under a *doctor's regular care* for the cause of your *disability,* starting from the date you were first *disabled;* and (ii) receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability.*

(c) You must send us written proof of: (i) your *disability;* (ii) your weekly earnings prior to the start of your *disability;* and (iii) any earnings from work while you are *disabled.*

Proof of earnings may consist of: (1) copies of your U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

Waiver Of Premium

Premiums for this insurance are waived while you are entitled to receive a payment from this *plan.*

To Continue Receiving Payments

To continue to receive payments from this *plan,* you must give us current proof of loss when we request it.

You must give proof that satisfies us as to the items listed below:

(a) your continued *disability;*

(b) continued *regular care* by a *doctor* that is appropriate for the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability;*

(c) earnings from work while you are *disabled;* and

(d) any other income that you are entitled to receive.

You must also give us current signed authorizations for release of medical and financial data when we request it.

You must give us such items within 90 days of the date we make each such request. If you do not, we have the right to suspend or stop your payments under this *plan.*

Right To Request Medical, Financial Or Vocational Assessment

We may ask you to take part in a medical, financial or vocational assessment as often as we feel is reasonably necessary. We will pay for all such assessments. If you do not take part in the assessment, we have the right to stop or suspend your payments under this *plan.*

Payment Of Benefits

We pay benefits to you if you are legally competent. If you are not, we pay benefits to the legal representative of your estate.

We pay benefits twice each month on a pro rata basis after the period for which they are payable.

Benefits to which you are entitled may remain unpaid at your death. Such benefits may be paid at our discretion to: (a) your estate; or (b) your spouse, parents, children, or brothers and sisters.

When Payments End

Your benefits from this *plan* will end on the earliest of the dates shown below:

(a) The date you are no longer *disabled.*

(b) The date you earn, or are able to earn, the maximum earnings allowed while *disabled* under this *plan.*

(c) The date you are able to perform the major duties of your *own job* on a full-time basis with reasonable accommodation that an employer is willing to provide.

(d) The date you no longer reside in the United States.

(e) The date you die.

(f) The end of the *maximum payment period.*

(g) The date you fail to give us required current proof of loss. This includes taking part in any medical, financial or vocational assessment we may require.

(h) The date you are no longer under the *regular care* of a *doctor.*

(i) The date you become eligible for any other group short term disability income plan.

The term "reasonable accommodation" means any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place. The modification or adjustment must make it possible for a *disabled* person to: (1) reach the same level of performance as a similarly situated non-disabled person; or (2) enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person. The modification or adjustment must not place an undue hardship on the employer.

CGP-3-STD2K-3.0 B335.0014

Maximum Payment Period

The *maximum payment period* is the longest time that benefits are paid by this *plan* for your *disability.*

For *disability* due to *injury* the *maximum payment period* is 13 weeks.

For *disability* due to *sickness,* the *maximum payment period* is 13 weeks.

Payments for a pre-existing condition will be limited to a maximum of 2 weeks.

If This Plan Ends

This insurance ends when the group plan ends. It also ends when this insurance is dropped from the group plan for all insureds, or for your class. If you are *disabled* when this insurance ends, we will treat you as if your insurance did not end. But, your benefit will be based on all of the terms of this *plan.*

CGP-3-STD2K-3.1 B335.0016

Your benefit is determined by the plan of benefits and your *insured earnings* in effect on the date your *disability* starts.

Any changes to this *plan* that take place while you are *disabled* will not affect how we determine your benefit. This is also true for any changes that take place during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability.*

Determining Your Weekly Benefit

Your *weekly benefit* is determined as shown below.

(a) Multiply your *insured earnings* by 60%. Round this amount to the nearest dollar.

(b) If the amount determined above is less than this *plan's maximum weekly benefit,* that amount is your *gross weekly benefit.*

If the amount determined above is equal to or more than this *plan's maximum weekly benefit,* your *gross weekly benefit* is equal to the *maximum weekly benefit.*

(c) From your *gross weekly benefit,* subtract the amount of any income listed in "Income We Integrate With" that you receive or are entitled to receive. The result is your *weekly benefit.*

The amount of your *gross weekly benefit* may be limited if the *plan sponsor* has not updated the amount of your *insured earnings* on the most recent reporting date prior to the start of your *disability.*

See the "Redetermination" section of this *plan* for details.

CGP-3-STD2K-4.0 B335.0018

Redetermination

As of the date of each change in your earnings, we use your then current *insured earnings* to set rates and to project benefit amounts and limits under this *plan.* However, you must be *actively-at-work* on a full-time basis on that date. If you are not, we do not do this until the date you return to *active work* on a full-time basis. But, changes in earnings will not apply to a *recurring disability.*

CGP-3-STD2K-4.1 B335.0023

Income We Integrate With

You may receive, or be entitled to receive, income shown in the list below. We will integrate your *gross weekly benefit* with such income to determine your *weekly benefit* from this *plan.*

- Commissions received, due to be received, or paid after *disability* benefits start. This includes vested and nonvested renewal commissions.
- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.
- Disability benefits from all group plans of: (1) the *plan sponsor;* or (2) your *employer.* This includes payments made by a group life insurance plan due to your *disability.* This does not include payments made from a group life insurance plan's: (a) accelerated death benefit; or (b) like provision that allows payment of such plan's proceeds due to terminal illness.
- Disability benefits from any other group plan.

- Benefits as shown below from: (1) the United States Social Security Act; (2) the Railroad Retirement Act; or (3) any other like U.S. or Canadian plan or act.

  (a) All disability benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your *disability;*

  (b) All unreduced retirement benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your qualification; and

  (c) all reduced retirement benefits paid to: (i) you; and (ii) your spouse and children due to your receipt of such benefits.

  We will integrate your *gross weekly benefit* with such benefits to which your spouse and children are entitled due to your receipt of or qualification for disability benefits. We do this without regard to: (a) your marital status; (b) where you live; (c) where your spouse lives; (d) where your child lives; or (e) any custody arrangements made on behalf of your child.

- *Retirement plan retirement benefits* funded for your benefit by: (1) the *plan sponsor;* or (2) your *employer.*

- *Retirement plan disability benefits.*

- *Retirement benefits* or *retirement plan disability benefits,* due to your *disability,* from any *government plan* other than those shown above.

- Benefits from: (1) a Workers' Compensation law; (2) an occupational disease law; or (3) any other act or law of like intent. This includes: (a) the Jones' Act; (b) the Longshoreman's and Harbor Workers' Compensation Act; or (c) any Maritime doctrine of Maintenance, Wages or Cure.

- Disability benefits from any third party when your *disability* is the result of the negligence or intentional tort liability of that third party.

- Payment from your *employer* as part of a termination agreement.

We integrate your *gross weekly benefit* with income shown above that you are entitled to receive without regard to the reason you are entitled to receive it.

Our right to reduce your benefit by such income shall not be negated by a transfer of claim liability to a third party. Payment by such third party by law, settlement, judgement, waiver or otherwise shall not negate our right.

Lump Sum Payments Of Other Income

Income with which we integrate may be paid in a lump sum. In this case, we take the equivalent weekly rate stated in the award into account when we determine your *weekly benefit.* If no weekly rate is given, we divide the lump sum payment by the number of calendar days in the period for which it was awarded. This will determine the daily rate. Then, multiply the daily rate by seven. The result is the prorated weekly rate.

To Determine Your Benefit (Cont.)

Cost Of Living Freeze

You may receive a cost of living increase in other income with which we integrate. In this case, we do not further reduce your *weekly benefit* by the amount of such increase.

Application For Other Income

You must apply for other income benefits to which you may be entitled. If these benefits are denied, you must appeal until: (a) all possible appeals have been made; or (b) we notify you that no further appeals are required.

If we feel you are entitled to receive such income benefits, we will estimate the amount due to you and your spouse and children. We will take this estimated amount into account when we determine your *weekly benefit.* But, we will not take this estimated amount into account if you sign our reimbursement agreement. In this agreement you promise: (a) to apply for any benefits for which you may be eligible; (b) to appeal any denial of such benefits until all possible appeals have been made; and (c) to repay any amount we overpaid due to an award of such benefits.

If we do reduce your *gross weekly benefit* by an estimated amount, we will adjust your *weekly benefit* when we receive written proof: (a) of the amount awarded; or (b) that the other income benefits have been denied; and no further appeals are possible. If we underpaid you, we pay the full amount of the underpayment in a lump sum.

We will assist you in applying for other income benefits.

CGP-3-STD2K-4.3 B335.0027

Partial Week Payment

You may be disabled for only part of a week. In this case, we compute your payment as 1/7th of the benefit to which you would be entitled for the week times the number of days you are disabled.

Overpayment Recovery

If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

CGP-3-STD2K-4.4 B335.0074

If You Work While Disabled

Income Earned During Disability

Subject to the other terms of this *plan, income earned during disability* is treated as shown below while this *plan* pays benefits.

We reduce your *weekly benefit* by 50% of your *income earned during disability.*

CGP-3-STD2K-5.0 B335.0032

Maximum Income Earned During Disability

This *plan* limits the amount of income you may earn, or may be able to earn, and still be considered *disabled.*

If your *income earned during disability* is more than 80% of your *insured earnings,* payments from this *plan* will end. Payments from this *plan* will also end if you are able to earn more than that limit.

CGP-3-STD2K-5.1 B335.0033

Recurring Disability

Your benefits from this *plan* will end because you cease to be *disabled.* In this case, a later *disability* may be treated as a *recurring disability.* The terms listed below must be met:

(a) You return to *active work* right after your benefits end;

(b) Your *disability* recurs less than two weeks after you were last entitled to benefits;

(c) Your later *disability* is due to the same cause of, or a cause related to the cause of, your earlier *disability;*

(d) This *plan* does not end during your return to *active work;*

(e) You do not become covered under any other group short term disability plan during the time you return to *active work;*

(f) During the time you return to *active work,* you stay insured by this *plan* and premium payments are made on your behalf; and

(g) Your benefits do not end because you have used up the *maximum payment period.*

Any changes in benefit or the *plan* which take place during your return to *active work,* will not apply to the *recurring disability.*

If the later *disability* is a *recurring disability,* you will not need to complete a new *elimination period* before becoming entitled to benefits. Your claim for *recurring disability* will be subject to the same terms of the *plan* as your earlier *disability.*

CGP-3-STD2K-6.0 B335.0034

Pre-Existing Conditions

A pre-existing condition is a *sickness* or *injury,* including all related conditions and complications, for which, in the look back period, you:

(a) receive advice or treatment from a *doctor;*

(b) take prescribed drugs; or

(c) receive other medical care or treatment, including consultation with a *doctor.*

You may have been prescribed drugs by a *doctor* for a condition to be taken during the look back period. In that case, such condition or a related condition will be considered pre-existing.

The "look back period" is the three months before the latest of: (a) the effective date of your insurance under this *plan;* (b) the effective date of a change that increases the benefits payable by this *plan;* and (c) the effective date of a change in your benefit election that increases the benefit payable by this *plan.*

A pregnancy that exists on the date your insurance under this *plan* starts is also a pre-existing condition.

For any *disability* due to a pre-existing condition, we limit the *maximum payment period* to 2 weeks; unless the *disability* starts after you complete at least one full day of *active work* after the date you are insured under this *plan* for 12 months in a row.

You may become *disabled* due to a pre-existing condition after: (a) a change which provides for an increase in the benefits payable by this *plan;* or (b) a change in your benefit election which increases the benefit payable by this *plan.* In this case, your benefit will be limited to the amount that would have been payable had the change not taken place. This limit does not apply if your *disability* starts after you complete at least one full day of *active work* after the change has been in force for 12 months in a row.

We do not cover any *disability* that starts before your insurance under this *plan.*

CGP-3-STD2K-8.0 B335.0230

Prior Coverage Credit

If this *plan* replaces a similar short term disability plan the *plan sponsor* had with another insurer, the pre-existing condition provision may not apply to you. This *plan* must start right after the old plan ends.

We credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision. If the old plan did not have a pre-existing condition provision, we credit any time you were covered under the old plan toward meeting this *plan's* pre-existing condition provision. We do this if: (a) you were covered under the old plan when it ended; and (b) you are *actively-at-work* and enroll for insurance on the effective date of this *plan.*

But, we limit the *maximum weekly benefit* under this *plan* if: (a) it is more than the old plan's maximum; (b) you become *disabled* due to a pre-existing condition; and (c) this *plan* pays benefits for such *disability* because we credit time as explained above. In this case, we limit the *maximum weekly benefit* to an amount equal to the old plan's maximum.

We deduct all payments made by the old plan under an extension provision.

CGP-3-STD2K-8.1 B335.0040

Not Covered

Exclusions This *plan* does not pay benefits for *disability* caused by, or related to:

(a) declared or undeclared war, act of war, or armed aggression;

(b) service in the armed forces, National Guard, or military reserves of any state or country;

(c) your taking part in a riot or civil disorder;

(d) your commission of, or attempt to commit a crime; or

(e) intentional self-inflicted injuries.

We do not cover any period of *disability* caused directly or indirectly by: (i) job related or on the job *injury;* or (ii) conditions for which benefits are payable by Workers' Compensation or like laws.

We do not pay benefits for any period of *disability:*

(1) during which you are confined to a facility as a result of your conviction of a crime;

(2) during which you are not receiving regular care by a *doctor;*

(3) during which you are not receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability;*

(4) which starts before you are insured by this *plan;* or

(5) during which your loss of earnings is not solely due to your *disability.*

CGP-3-STD2K-9.0 B335.0041

Definitions

Active Work, Actively-At-Work Or Actively Working You are able to perform and are performing all of the regular duties of your work for your *employer,* on a full-time basis at: (a) one of your *employer's* usual places of business; (b) some place where your *employer's* business requires you to travel; or (c) any other place you and your *employer* have agreed on for your work.

CGP-3-STD2K-10.0 B335.0045

Disability Or Disabled These terms mean you have physical, mental or emotional limits caused by a current *sickness* or *injury.* And, due to these limits, you are not able to perform, on a full-time basis, the major duties of your *own job.*

You are not *disabled* if you earn, or are able to earn, more than this *plan's* maximum allowed *income earned during disability.*

You may be required, on average, to work more than 40 hours per week. In this case, you are not *disabled* if you are able to perform the major duties of your *own job* for 40 hours per week.

Loss of a professional or occupational license will not, in itself, constitute *disability.*

CGP-3-STD2K-10.2 B335.0048

Doctor Any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice. We do not recognize you, or your spouse, child, parent, sibling, or business associate, as a *doctor* with respect to your claim for this *plan's* benefits.

Elimination Period The period of time you must be *disabled,* due to a covered *disability,* before this *plan's* benefits are payable.

Any days during which you return to *active work* will not count toward the *elimination period.* The *elimination period* will be extended by one day for each day of *active work.* If you become eligible under any other group short term disability plan while you are at *active work,* you will not be entitled to benefits from this *plan.*

Employer The business entity that employs you and is: (a) the *plan sponsor;* or (b) associated with the *plan sponsor.*

CGP-3-STD2K-10.3 B335.0050

Government Plan Any of the following: (1) the United States Social Security Act; (2) the Railroad Retirement Act; (3) the Canadian Pension Plan; or (4) any other plan provided under the laws of a state, province or any other political subdivision. It also includes: (a) any public employee retirement plan; or (b) any plan provided in place of the above named plan or acts. It does not include: (i) any Workers' Compensation Act or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages, or Cure.

Gross Weekly Benefit This *plan's weekly benefit* before it is integrated with other income and earnings.

Income Earned During Disability The weekly income you earn from working while *disabled.* It includes any income you earn while *disabled* but which is returned to your *employer,* partnership, or any other similar business arrangement to cover any business or overhead expenses.

Injury A bodily *injury* due to an accident that occurs, independent of all other causes, while you are insured by this *plan.* We will cover a *disability* caused by an *injury* when the *disability* starts within 90 days of the date of such *injury.*

CGP-3-STD2K-10.4 B335.0051

Insured Earnings Only your earnings from the *employer* will be included as *insured earnings.*

The full amount of your *insured earnings* is used to calculate benefit amounts and limits under this *plan.* We base all calculations on the amount of your *insured earnings* as reported by the *plan sponsor* on the most current reporting date prior to the start of your *disability.* See the "Redetermination" section of this *plan.*

Insured earnings includes your contributions deposited into a cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457. Earnings based on excluded income and *employer* contributions deposited into such 401(k), 403(b) or 457 plan are excluded.

For all covered persons, *insured earnings* means your rate of weekly earnings, excluding bonuses, commissions, expense accounts and any other extra compensation, as reported by the *plan sponsor.* We do not include pay for hours worked or billed over 40 per week.

CGP-3-STD2K-10.5 B335.0554

Maximum Payment Period The longest time that benefits are paid by this *plan.*

Own Job Your job for the *employer.* We use the job description provided by the *plan sponsor* to determine the duties and requirements of your *own job.*

Plan Sponsor The employer, association, union, trustee, or other group to which this *plan* is issued.

Recurring Disability A later *disability* that: (a) is related to an earlier *disability* for which this *plan* paid benefits; and (b) meets the conditions described in "Recurring Disability."

Regular Care You are being treated by, or in consultation with, a *doctor* at a frequency that is consistent with your condition. The requirement for *regular care* does not apply if you have reached your maximum point of recovery yet are still *disabled* under the terms of this *plan.*

CGP-3-STD2K-10.6 B335.0061

Retirement Plan A defined benefit or defined contribution plan funded wholly or in part by the *employer's* deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans: (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans.

Retirement Plan **"retirement benefits"** are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability(as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits.* When such payments do not reduce the normal retirement amount, they are **"disability benefits."**

Sickness An illness or disease. Pregnancy is treated as a *sickness* under this *plan.*

We, Us, And Guardian The Guardian Life Insurance Company of America.

Weekly Benefit This *plan's gross weekly benefit* reduced by other income.

If you are working while *disabled,* your *weekly benefit* will be further reduced based on the amount of your *income earned during disability.* See "If You Work While Disabled."

You The person insured by this *plan.*

LONG TERM DISABILITY HIGHLIGHTS

This page provides a quick guide to some of the plan features about which people most often want to know. But it's not a complete description of your long term disability plan. Read the following pages carefully for a complete explanation of what we pay, limit, and exclude.

CGP-3-LTD2K-HL B380.1513

Plan A

Own Occupation Period

The first 24 months of benefit payments from this plan.

CGP-3-LTD2K-HL B380.1578

Elimination Period

For disability due to injury . . . . . 90 days

For disability due to sickness . . . . . 90 days

CGP-3-LTD2K-HL B380.1526

Maximum Payment Period

See the following table:

Age when disability starts	Maximum payment period
Under age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

CGP-3-LTD2K-HL B380.1531

Benefit Percent 60%

CGP-3-LTD2K-HL B380.1534

Maximum Monthly Benefit $5,000.00

CGP-3-LTD2K-HL B380.1523

LONG TERM DISABILITY INCOME INSURANCE

This insurance replaces part of your income if you become disabled due to sickness or injury.

We decide: (a) if you are eligible for this insurance; (b) if you meet the requirements for benefits to be paid; and (c) what benefits are to be paid by this plan. We also interpret how this plan is to be administered. What we pay and the terms for payment are explained below.

All terms in *italics* are defined terms with special meanings. Their definitions are shown at the end of this section. Other terms are defined where they are used.

Claim Provisions

Your Duties If you become *disabled* due to *sickness* or *injury* while insured by this *plan,* you must:

(a) Give notice of claim as soon as possible after the date of your *injury* or the start of your *sickness.* Prompt notice will permit us to start case management. See the "Rehabilitation and Case Management" section of this *plan* for details.

(b) Give a complete account of the details of your *sickness* or *injury.* This will include: (i) the cause of your *disability,* if known; (ii) a description of your *sickness* or the accident that caused your *injury;* and (iii) a list of all *doctors,* hospitals, or other facilities where you have been treated for the cause of your *disability.*

(c) Allow release of medical and/or income data needed to assess your claim.

(d) Give periodic medical updates as required by this *plan.*

(e) Take part in any medical, financial or vocational assessment as required by this *plan.*

(f) Apply for other income benefits to which you may be entitled.

(g) Promptly report to us the receipt or denial of such other income benefits. And, appeal any denials to the extent possible.

(h) Promptly report to us changes in your personal status. This includes: (i) change of address or phone number; (ii) changes in how your *disability* affects your daily living; and (iii) changes in your level of social, volunteer or business activities.

(i) If we overpay benefits, promptly report and repay any amount overpaid.

(j) If you are working while *disabled,* promptly report to us the amount of your income from such work.

(k) Give us proof of your earnings for the period prior to your *disability* and while you are *disabled.*

Notice You must send us written notice of your intent to file a claim under this *plan* as described in this certificate's "Accident and Health Claims Provisions." Notice must include:

(a) your full name; phone number; social security number, and group number;

(b) the date of your last day worked; the number of hours you worked; and your job title;

(c) your *employer* contact and phone number;

(d) a statement of the nature of your *disability;* and whether or not it is work-related;

(e) your *doctor's* name, address and phone number.

For details, you can call Guardian at 1-800-538-4583.

Proof Of Loss When we receive your notice, we will provide you with a claim form for filing proof of loss. This form requires data from you, the *plan sponsor,* and the *doctor(s)* treating you for your *sickness* or *injury.* Proof of loss must be given to us within the time stated in this certificate's "Accident and Health Claims Provisions." If you do not receive a claim form within 15 days of the date you sent your notice, you should send us written proof of loss without waiting for the form.

We require the items listed below as proof of loss:

(a) During the *elimination period* and the *own occupation* period, medical evidence in support of the limits on your ability to perform your *own occupation,* starting on the date you first became *disabled.* This proof is required from all *doctors* who have treated you for the cause of your *disability.*

After the *own occupation* period, medical evidence in support of the limits on your ability to perform any *gainful work.*

(b) Proof that you have applied for all other sources of income to which you may be entitled, that may affect your payment from this *plan.*

(c) Proof of receipt of other income that may affect your payment from this *plan.*

(d) Your signed authorization for release of medical and/or financial data by the sources of such data.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Long Term Disability Claims Department
P.O. Box 26025
Lehigh Valley, PA 18002-6025

How Payments Start

To start getting payments from this *plan,* you must meet all of the conditions listed below:

(a) You must: (i) become *disabled* while insured by this *plan;* and (ii) remain *disabled* and insured for this *plan's elimination period.*

(b) You must be: (i) under a *doctor's regular care* for the cause of your *disability,* starting from the date you were first *disabled;* and (ii) receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability.*

(c) You must send us written documentation of: (i) medical evidence in support of the limits causing your *disability;* (ii) your monthly earnings prior to the start of your *disability;* and (iii) any earnings from work while you are *disabled.*

Proof of earnings may consist of: (1) copies of your U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

Waiver Of Premium

Premiums for this insurance are waived while you are entitled to receive a payment from this *plan.*

To Continue Receiving Payments

To continue to receive payments from this *plan,* you must give us current proof of loss when we request it.

You must give proof that satisfies us as to the items listed below:

(a) medical evidence in support of the limits causing your continued *disability;*

(b) continued *regular care* by a *doctor* that is appropriate for the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability;*

(c) earnings from work while you are *disabled;* and

(d) any other income that you are entitled to receive.

You must also give us current signed authorizations for release of medical and financial data when we request it.

You must permit such assessments and give us such items within 90 days of the date we make each such request. If you do not, we have the right to suspend or stop your payments under this *plan.*

Right To Request Medical Financial Or Vocational Assessment

We may ask you to take part in a medical, financial or vocational assessment as often as we feel is reasonably necessary. We will pay for all such assessments. If you do not take part in the assessment, we have the right to stop or suspend your payments under this *plan.*

Payment Of Benefits

We pay benefits to you if you are legally competent. If you are not, we pay benefits to the legal representative of your estate.

We pay benefits once each month at the end of the period for which they are payable.

Benefits to which you are entitled may remain unpaid at your death. Such benefits may be paid at our discretion to: (a) your estate; or (b) your spouse, parents, children, or brothers and sisters.

CGP-3-LTD2K-2.1 B380.0015

When Benefits End

When Payments End

Your benefits from this *plan* will end on the earliest of the dates shown below:

(a) The date you are no longer *disabled.*

(b) The date you earn, or are able to earn, the maximum earnings allowed while *disabled* under this *plan.*

(c) The date you are able to perform the major duties of your *own occupation* on a full-time basis with reasonable accommodation that an employer is willing to provide.

(d) After the *own occupation* period, the date you are able to perform the major duties of any *gainful work* on a full-time basis with reasonable accommodation that an employer is willing to provide.

(e) The date you no longer reside in the United States.

(f) The date you die.

(g) The end of the *maximum payment period.*

(h) The date you fail to give us required current proof of loss. This includes taking part in any medical, financial or vocational assessment we may require.

(i) The date you are no longer under the *regular care* of a *doctor.*

(j) The date payments end in accord with a *rehabilitation agreement.*

(k) The date you refuse to take part in a *rehabilitation program.*

The term "reasonable accommodation" means any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place. The modification or adjustment must make it possible for a *disabled* person to: (1) reach the same level of performance as a similarly situated non-disabled person; or (2) enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person. The modification or adjustment must not place an undue hardship on the employer.

CGP-3-LTD2K-3.0 B380.0019

Plan ID A

Maximum Payment Period

The *maximum payment period* is the longest time that benefits are paid by this *plan* for your *disability.* It is determined by the table shown below.

But, it may be less than that shown due to the nature of your *disability.* See "Special Limitations."

Age when disability starts	Maximum payment period
Under age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

CGP-3-LTD2K-3.1 B380.2068

Special Limitations

We limit the *maximum payment period,* if you are *disabled* due to a condition listed below.

The *maximum payment period* for all such periods of *disability* is 24 months. This is a combined maximum for all such conditions and all periods of *disability.*

We limit the *maximum payment period* for *disabilities* caused or contributed to by the following conditions:

- *Mental or emotional conditions*
- Drug or alcohol abuse
- Musculoskeletal and connective tissue disorders including, but not limited to:
  - Sprains or strains of joints and muscles
  - Soft tissue conditions
  - Repetitive motion syndromes or injuries
  - Fibromyalgia
- Chronic fatigue conditions including, but not limited to:
  - Chronic fatigue syndrome
  - Chronic fatigue immunodeficiency syndrome
  - Epstein-barr syndrome
- Chemical and environmental sensitivities
- Headache

- Chronic pain, myofascial pain
- Gastro-esophageal reflux disorder
- Irritable bowel syndrome
- Vestibular dysfunction, vertigo, dizziness

This limitation will not apply to *disabilities* caused or contributed to by the following conditions:

- Schizophrenia
- Dementia
- Organic brain syndromes
- Amnesia syndromes
- Organic delusional or hallucinogenic syndromes
- Arthritis
- Ruptured intervertebral discs
- Spinal fractures
- Osteopathies
- Spinal tumors, malignancy or vascular malformations
- Radiculopathies, documented by EMG
- Spondylolisthesis, Grade II or higher
- Myelopathies
- Demyelinating diseases
- Traumatic spinal cord necrosis

No benefits will be paid for *disability* due to a *mental or emotional condition* or drug or alcohol abuse if you are not receiving treatment for the cause of the *disability* from a provider, or in a facility that is: (a) licensed by the state to provide treatment for such condition; and (b) accredited or approved by the Joint Commission on the Accreditation of Health Care Facilities or Medicare.

If payments under this *plan* would end due to the limits in this section, we may extend such payments, as shown below. But, you must meet all of the following conditions: (a) you must be *disabled* due to a condition named above; (b) you must be an inpatient in a qualified institution because of your *disability;* and (c) you must have been treated as an inpatient for at least 14 days in a row. In such case, we extend payments until the earliest of: (i) 90 days from the date of your discharge; (ii) the end of this *plan's maximum payment period;* or (iii) the date your *disability* ends.

The term "qualified institution" means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your *disability.*

If This Plan Ends

This insurance ends when the group plan ends. It also ends when this insurance is dropped from the group plan for all insureds, or for your class. If you are *disabled* when this insurance ends, we will treat you as if your insurance did not end. But, your benefit will be based on all of the terms of this *plan.*

CGP-3-LTD2K01-3.2 B380.0430

To Determine Your Benefit

Plan A

Your benefit is determined by the plan of benefits and your *insured earnings* in effect on the date your *disability* starts.

Any changes to this *plan* that take place while you are *disabled* will not affect how we determine your benefit. This is also true for any changes that take place during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability.*

Determining Your Monthly Benefit

Your *monthly benefit* is determined as shown below.

(a) Multiply your *insured earnings* by 60%. Round this amount to the nearest dollar.

(b) If the amount determined above is less than this *plan's maximum monthly benefit,* that amount is your *gross monthly benefit.*

If the amount determined above is equal to or more than this *plan's maximum monthly benefit,* your *gross monthly benefit* is equal to the *maximum monthly benefit.*

(c) From your *gross monthly benefit,* subtract the amount of any income listed in "Income We Integrate With" that you receive or are entitled to receive. The result is your *monthly benefit.*

The amount of your *gross monthly benefit* may be limited if:

(a) you have not provided any proof of insurability required by this *plan;*

(b) we have not given you written approval of such proof; or

(c) the *plan sponsor* has not updated the amount of your *insured earnings* to reflect your then current *insured earnings* on the most recent reporting date prior to the start of your *disability.*

See the "Redetermination" and "Proof of Insurability" section of this *plan* for details.

CGP-3-LTD2K-4.0 B380.1956

Redetermination

This plan redetermines *insured earnings* for each covered person on the date a change in a covered person's *insured earnings* occurs. The *plan sponsor* must report updates to all covered persons' *insured earnings* as they occur. Changes to a covered person's *insured earnings* are subject to any proof of insurability requirements of this *plan.* As of this *plan's* redetermination date, we use a covered person's *insured earnings* on record with us to: (a) set rates; (b) project benefit amounts and limits; and (c) calculate premium payable under this *plan.* However, the covered person must be *actively-at-work* on a full-time basis on that date. If he or she is not, we do not do this until the date he or she returns to *active work* on a full-time basis. But, changes in earnings will not apply to a *recurring disability.*

CGP-3-LTD2K01-4.2 B380.0435

Income We Integrate With

You may receive, or be entitled to receive, income shown in the list below. We will integrate your *gross monthly benefit* with such income to determine your *monthly benefit* from this *plan.*

- Commissions received, due to be received, or paid after *disability* benefits start. This includes vested and nonvested renewal commissions.
- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.
- Disability benefits from all group plans of: (1) the *plan sponsor;* or (2) your *employer.* This includes payments made by a group life insurance plan due to your *disability.* This does not include payments made from a group life insurance plan's: (a) accelerated death benefit; or (b) like provision that allows payment of such plan's proceeds due to terminal illness.
- Disability benefits from any other group plan.
- Income from a sick leave or salary continuance plan. This applies whether such plan is sponsored on a formal or informal basis. This includes lump sum or recurrent payments of accrued sick leave benefits.
- Benefits as shown below from: (1) the United States Social Security Act; (2) the Railroad Retirement Act; or (3) any other like U.S. or Canadian plan or act.

  (a) All disability benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your *disability;*

  (b) All unreduced retirement benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your qualification; and

  (c) all reduced retirement benefits paid to: (i) you; and (ii) your spouse and children due to your receipt of such benefits.

We will integrate your *gross monthly benefit* with such benefits to which your spouse and children are entitled due to your receipt of, or qualification for, disability benefits. We do this without regard to: (a) your marital status; (b) where you live; (c) where your spouse lives; (d) where your child lives; or (e) any custody arrangements made on behalf of your child.

- *Retirement plan retirement benefits* funded for your benefit by: (1) the *plan sponsor;* or (2) your *employer.*
- *Retirement plan disability benefits.*
- *Retirement benefits* or *retirement plan disability benefits,* due to your *disability,* from any *government plan* other than those shown above.
- Benefits from: (1) a Workers' Compensation law; (2) an occupational disease law; or (3) any other act or law of like intent. This includes: (a) the Jones' Act; (b) the Longshoreman's and Harbor Workers' Compensation Act; or (c) any Maritime doctrine of Maintenance, Wages or Cure.
- Disability benefits from any third party when your *disability* is the result of the negligence or intentional tort liability of that third party.
- Payment from your *employer* as part of a termination agreement.

We integrate your *gross monthly benefit* with income shown above that you are entitled to receive without regard to the reason you are entitled to receive it.

Our right to reduce your benefit by such income shall not be negated by a transfer of claim liability to a third party. Payment by such third party by law, settlement, judgement, waiver or otherwise shall not negate our right.

Lump Sum Payments Of Other Income

Income with which we integrate may be paid in a lump sum. In this case, we take the equivalent monthly rate stated in the award into account when we determine your *monthly benefit.* If no monthly rate is given, we pro-rate the lump sum over the lesser of: (a) 60 months; or (b) the *maximum payment period.*

Cost Of Living Freeze

You may receive a cost of living increase in other income with which we integrate. In this case, we do not further reduce your *monthly benefit* by the amount of such increase.

Application For Other Income

You must apply for other income benefits to which you may be entitled. If these benefits are denied, you must appeal until: (a) all possible appeals have been made; or (b) we notify you that no further appeals are required.

If we feel you are entitled to receive such income benefits, we will estimate the amount due to you and your spouse and children. We will take this estimated amount into account when we determine your *monthly benefit.* But, we will not take this estimated amount into account if you sign our reimbursement agreement. In this agreement you promise: (a) to apply for any benefits for which you may be eligible; (b) to appeal any denial of such benefits until all possible appeals have been made; and (c) to repay any amount we overpaid due to an award of such benefits.

If we do reduce your *gross monthly benefit* by an estimated amount, we will adjust your *monthly benefit* when we receive written proof: (a) of the amount awarded; or (b) that the other income benefits have been denied; and no further appeals are possible. If we underpaid you, we pay the full amount of the underpayment in a lump sum.

We will assist you in applying for other income benefits.

CGP-3-LTD2K-4.4 B380.0062

Minimum Payment The minimum monthly payment for *disability* under this *plan* is $50.00.

Partial Month Payment You may be *disabled* for only part of a month. In this case, we compute your payment as 1/30th of the benefit to which you would be entitled for the full month times the number of days you are *disabled.* Payment will not be made for more than 30 days in any month.

Overpayment Recovery If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

CGP-3-LTD2K-4.5 B380.0064

If You Work While Disabled

Income Earned During Disability Subject to the other terms of this *plan,* if you are working to your *maximum capacity,* income earned during disability is treated as shown below while this *plan* pays benefits. In all cases, your *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

1. For each of the first 12 months after you return to work, add your *gross monthly benefit* and your *income earned during disability.*
   (a) If the sum is not more than 100% of your *insured earnings,* we do not reduce your *monthly benefit* for that month.
   (b) If the sum is more than 100% of your *insured earnings,* we reduce your *monthly benefit* for that month by the amount over 100% of your *insured earnings.*

2. For each month after 12 months of work while *disabled:*

   (a) If your *income earned during disability* is less than 20% of your *insured earnings,* we do not reduce your *monthly benefit* for that month.

   (b) If your *income earned during disability* is 20% or more of your *insured earnings,* we reduce your *monthly benefit* for that month by 50% of your *income earned during disability.*

CGP-3-LTD2K01-5.0 B380.0442

Part-Time Earnings Capacity

If you are able to work *part-time* while *disabled,* but you are not working to your *maximum capacity,* we adjust the *monthly benefit* as follows.

During the *own occupation* period, we reduce your *monthly benefit* by 50% of the income you would currently be able to earn, if working to your *maximum capacity,* in your *own occupation.* After the *own occupation* period, we reduce your *monthly benefit* by 50% of the income you would currently be able to earn, if working to your *maximum capacity,* in any *gainful occupation.*

Maximum Income Earned During Disability

This *plan* limits the amount of income you may earn, or may be able to earn, and still be considered *disabled.*

If your *income earned during disability* is more than the limit shown below, payments from this *plan* will end. Payments from this *plan* will also end if you are able to earn more than the limit shown below.

(a) During the *own occupation* period, the limit is 80% of your *insured earnings.*

(b) After the *own occupation* period, the limit is 60% of your *insured earnings.*

In all cases, your *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

CGP-3-LTD2K01-5.1 B380.0518

Indexing

If you return to work while *disabled,* we adjust your *insured earnings* each year. We do this by means of an indexing factor. This factor increases the amount of income you may earn and still be considered *disabled.* This adjustment does not increase your *gross monthly benefit, monthly benefit,* or any other benefit under this *plan.*

We make the first indexing adjustment after you: (a) have returned to work; and (b) have received 12 monthly payments in a row from this *plan.*

To make the first adjustment, we multiply your *insured earnings* by the indexing factor for that year. To make adjustments in each later year, we multiply the amount of your last indexed *insured earnings* by the indexing factor for the current year.

The indexing factor is the lesser of: (a) 10%; or (b) one-half of the percentage change in the *CPI-W* for the prior calendar year.

CGP-3-LTD2K-5.2 B380.0073

Your benefits from this *plan* will end because you cease to be *disabled.* In this case, a later *disability* may be treated as a *recurring disability.* The terms listed below must be met:

(a) You return to *active work* right after your benefits end;

(b) Your *disability* recurs less than six months after you were last entitled to benefits;

(c) Your later *disability* is due to the same cause of, or a cause related to the cause of, your earlier *disability;*

(d) This *plan* does not end during your return to *active work;*

(e) You do not become covered under any other similar group income replacement plan during the time you return to *active work;* and

(f) During the time you return to *active work,* you stay insured by this *plan* and premium payments are made on your behalf.

(g) Your benefits do not end because you have used up the *maximum payment period.*

Any changes in benefit or the *plan* which take place during your return to *active work,* will not apply to the *recurring disability.*

If the later *disability* is a *recurring disability,* you will not need to complete a new *elimination period* before becoming entitled to benefits. Your claim for *recurring disability* will be subject to the same terms of the *plan* as your earlier *disability.*

CGP-3-LTD2K-6.0 B380.0075

Income Recovery Benefit

This *plan* may pay an Income Recovery Benefit, if *monthly benefits* cease because you are no longer *disabled.*

When And How The Income Recovery Benefit Starts

To be eligible for the Income Recovery Benefit, you must be:

(a) able to perform the major duties of your *own occupation;* and

(b) working in your *own occupation* the same number of hours as you did prior to *disability;* and

(c) unable to earn this *plan's* maximum allowable *income earned during disability,* due to the *sickness* or *injury* which caused the prior *disability.*

What We Pay

We pay this benefit monthly, in arrears. We determine the amount we pay in two steps. In step one, we compute the following: (a) your *gross monthly benefit* as of the last month you were *disabled* under the terms of this *plan;* less (b) any other income this *plan* integrates with that you are entitled to receive. In step two we make a current earnings adjustment. We add: (a) your *gross monthly benefit* as of the last month you were *disabled* under the terms of this *plan;* and (b) your current monthly earnings. If such sum exceeds 100% of your *insured earnings,* we pay the amount in step one less the excess over 100%. If such sum does not exceed 100%, we pay the amount in step one.

When The Income Recovery Benefit Ends

We stop paying this benefit on the earliest of:

(a) the date you are able to earn this *plan's* maximum allowable *income earned during disability;*

(b) the date you become *disabled;*

(c) the date you stop working;

(d) the date 12 consecutive months after the first Income Recovery Benefit is paid; or

(e) the end of the *maximum payment period.*

We will not pay more than 12 monthly Income Recovery Benefit payments following any one period of *disability,* including any *recurrent disability.*

Services Available

Social Security Assistance

We may feel you are qualified for Social Security disability benefits. If so, we may offer to help you apply for them. If such benefits are under review by Social Security, we may also offer to help you keep them.

We may offer to help:

(a) Fill out your application for such benefits, and any related forms;

(b) Find suitable legal counsel; and

(c) Give medical and vocational data needed to file your claim.

You must apply for all income benefits for which you may be eligible, whether or not you use our help. Using our help does not cancel your duties shown in the "Application for Other Income" section of this *plan.*

Rehabilitation And Case Management

Case management starts when we are notified of your *disability.*

We will review your *disability* to see if certain services are likely to help you return to *gainful work.* If needed, we may ask for more medical or vocational information.

When our review is complete, we may offer you a *rehabilitation program.* We have the right to suspend or end your *monthly benefit* if you do not accept it.

The *rehabilitation program* will start when a written *rehabilitation agreement* is signed by: (1) you; (2) us; and (3) your *employer,* if needed. The program may include, but is not limited to:

(a) vocational assessment of your work potential;

(b) coordination and transition planning with an employer for your return to work;

(c) consulting with your *doctor* on your return to work and need for accommodations;

(d) training in job seeking skills and resume preparation;

(e) retraining;

(f) child care expense aid; and

(g) aid in worksite alteration made to comply with the Americans with Disabilities Act. This includes a one-time payment of up to $2,500.00.

We have the right to determine which services are appropriate.

If you accept the *rehabilitation agreement,* we will pay an enhanced benefit. The enhanced benefit will be 110% of the *monthly benefit* that would otherwise be paid. This enhanced benefit will be payable as of the first *monthly benefit* after the *rehabilitation program* starts.

We stop paying the enhanced benefit on the earliest of:

(a) The date your benefits from this *plan* end,

(b) The date you violate the terms of the *rehabilitation agreement;*

(c) The date you end the *rehabilitation program;* and

(d) The date the *rehabilitation agreement* ends.

If you end a *rehabilitation program* without our consent, you must repay any enhanced benefits paid.

Pre-Existing Conditions

Pre-Existing Conditions

A pre-existing condition is a *sickness* or *injury,* including all related conditions and complications, for which, in the look back period, you:

(a) receive advice or treatment from a *doctor;*

(b) take prescribed drugs; or

(c) receive other medical care or treatment, including consultation with a *doctor.*

You may have been prescribed drugs by a *doctor* for a condition to be taken during the look back period. In that case, such condition or a related condition will be considered pre-existing.

The "look back period" is the six months before the latest of: (a) the effective date of your insurance under this *plan;* (b) the effective date of a change that increases the benefits payable by this *plan;* and (c) the effective date of a change in your benefit election that increases the benefit payable by this *plan.*

A pregnancy that exists on the date your insurance under this *plan* starts is also a pre-existing condition.

No benefits are payable for *disability* due to a pre-existing condition, unless the *disability* starts after you complete at least one full day of *active work* after the date you are insured under this *plan* for 24 months in a row.

You may become *disabled* due to a pre-existing condition after: (a) a change which provides for an increase in the benefits payable by this *plan;* or (b) a change in your benefit election which increases the benefit payable by this *plan.* In this case, your benefit will be limited to the amount that would have been payable had the change not taken place. This limit does not apply if your *disability* starts after you complete at least one full day of *active work* after the change has been in force for 24 months in a row.

We do not cover any *disability* that starts before your insurance under this *plan.*

CGP-3-LTD2K-9.0 B380.0090

Prior Coverage Credit

If this *plan* replaces a similar income replacement plan the *plan sponsor* had with another insurer, the pre-existing condition provision may not apply to you. This *plan* must start right after the old plan ends.

We credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision. If the old plan did not have a pre-existing condition provision, we credit any time you were covered under the old plan toward meeting this *plan's* pre-existing condition provision. We do this if: (a) you were covered under the old plan when it ended; and (b) you are *actively-at-work* and enroll for insurance on the effective date of this *plan.*

But, we limit the *maximum monthly benefit* under this *plan* if: (a) it is more than the old plan's maximum; (b) you become *disabled* due to a pre-existing condition; and (c) this *plan* pays benefits for such *disability* because we credit time as explained above. In this case, we limit the *maximum monthly benefit* to an amount equal to the old plan's maximum.

We deduct all payments made by the old plan under an extension provision.

CGP-3-LTD2K-9.1 B380.0092

Not Covered

Exclusions

This *plan* does not pay benefits for *disability* caused by, or related to:

(a) declared or undeclared war, act of war, or armed aggression;

(b) service in the armed forces, National Guard, or military reserves of any state or country;

(c) your taking part in a riot or civil disorder;

(d) your commission of, or attempt to commit a crime; or

(e) intentional self-inflicted injuries.

We do not pay any benefits for any period of *disability:*

(1) during which you are confined to a facility as a result of your conviction of a crime;

(2) during which you are not receiving regular care by a *doctor;*

(3) during which you are not receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability;*

(4) which starts before you are insured by this *plan;* or

(5) during which your loss of earnings is not solely due to your *disability.*

CGP-3-LTD2K-10.0 B380.0093

Definitions

Active Work, Actively-At-Work Or Actively Working You are able to perform and are performing all of the regular duties of your work for your *employer,* on a full-time basis at: (a) one of your *employer's* usual places of business; (b) some place where your *employer's* business requires you to travel; or (c) any other place you and your *employer* have agreed on for your work.

CGP-3-LTD2K-12.0 B380.0098

CPI-W That part of the United States Department of Labor Consumer Price Index that measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. The change in cost is expressed as a percentage of the cost of those goods and services in a base period. When we compute the change in *CPI-W,* we use the value of the *CPI-W* published in December of that year and the value published in December of the prior year. If the Department of Labor stops publishing the *CPI-W,* we have the right to use some other similar standard.

CGP-3-LTD2K-12.2 B380.0100

Disability Or Disabled These terms mean you have physical, mental or emotional limits caused by a current *sickness* or *injury.* And, due to these limits, you are not able to perform the major duties of your *own occupation* or any *gainful work* as shown below:

(1) During the *elimination period* and the *own occupation* period, you are not able to perform, on a full-time basis, the major duties of your *own occupation.*

(2) After the end of the *own occupation* period, you are not able to perform, on a full-time basis, the major duties of any *gainful work.*

You are not *disabled* if you earn, or are able to earn, more than this *plan's* maximum allowed *income earned during disability.*

You may be required, on average, to work more than 40 hours per week. In this case, you are not *disabled* if you are able to work for 40 hours per week.

Loss of a professional or occupational license will not, in itself, constitute *disability.*

CGP-3-LTD2K-12.3 B380.0102

Doctor Any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice. We do not recognize you, or your spouse, child, parent, sibling, or business associate, as a *doctor* with respect to your claim for this *plan's* benefits.

Elimination Period The period of time you must be *disabled,* due to a covered *disability,* before this *plan's* benefits are payable.

Any days during which you return to *active work* will not count toward the *elimination period.* The *elimination period* will be extended by one day for each day of *active work.* If you become eligible under any other similar group income replacement plan while you are at *active work,* you will not be entitled to benefits from this *plan.*

Employer The business entity that employs you and is: (a) the *plan sponsor;* or (b) associated with the *plan sponsor.*

CGP-3-LTD2K-12.10 B380.0112

Gainful Occupation or Gainful Work Work for which you are, or may become, qualified by: (a) training; (b) education; or (c) experience. When you are able to perform such work on a full-time basis, you can be expected to earn at least 60% of your indexed *insured earnings,* within 12 months of returning to work.

Government Plan Any of the following: (1) the United States Social Security Act; (2) the Railroad Retirement Act; (3) the Canadian Pension Plan; or (4) any other plan provided under the laws of a state, province or any other political subdivision. It also includes: (a) any public employee retirement plan; or (b) any plan provided in place of the above named plan or acts. It does not include: (i) any Workers' Compensation Act or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages, or Cure.

Gross Monthly Benefit This *plan's monthly benefit* before it is reduced by other income and earnings.

Income Earned During Disability The monthly income you earn from working while *disabled.* It includes any income you earn while *disabled* but which is returned to your *employer,* partnership, or any other similar business arrangement to cover any business or overhead expenses.

Injury A bodily *injury* due to an accident that occurs, independent of all other causes, while you are insured by this *plan.* We will cover a *disability* caused by an *injury* when the *disability* starts within 90 days of the date of such *injury.*

CGP-3-LTD2K01-12.11 B380.0458

Insured Earnings Only your earnings from the *employer* will be included as *insured earnings.*

We calculate benefit amounts and limits based on the amount of your *insured earnings* on record with us as of the Redetermination date immediately prior to the start of your *disability.* See the "Redetermination" section of this *plan.*

Insured earnings includes your contributions deposited into a cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457. Earnings based on excluded income and *employer* contributions deposited into such 401(k), 403(b) or 457 plan are excluded.

For all covered persons, *insured earnings* means your rate of monthly earnings, excluding bonuses, commissions, expense accounts, and any other extra compensation, as reported by the *plan sponsor.* We do not include pay for hours worked or billed over 40 per week. Such earnings are multiplied by 4.333.

CGP-3-LTD2K01-12.12 B380.2124

Maximum Capacity During the *own occupation* period, the fullest extent of work you are able to do in your *own occupation.* After the *own occupation* period, the fullest extent of work you are able to do in any *gainful occupation.* We decide the fullest extent of work you are able to do based on objective data provided by: (a) your treating *doctor;* (b) impartial medical or vocational exams; (c) peer review specialists; (d) functional capacities exams; and (e) other medical and vocational specialists whose area of expertise is appropriate to your *disability.*

Maximum Payment Period The longest time that benefits are paid by this *plan.*

Mental Or Emotional Conditions Include, but are not limited to: (a) neurosis; (b) psychoneurosis; (c) psychosis; (d) psychopathy; and (e) any other mental or emotional disorder.

Monthly Benefit This *plan's gross monthly benefit* reduced by other income. If you are working while *disabled,* your *monthly benefit* will be further reduced based on the amount of your *income earned during disability.* See the "If You Work While Disabled" provision of this *plan* for how this is done.

CGP-3-LTD2K01-12.13 B380.0489

Own Occupation Your occupation as done in the general labor market in the national economy. To determine the duties and requirements of your *own occupation,* we use: (a) the job description provided by the *plan sponsor;* and (b) the duties and requirements of that occupation as shown in the most recent version of the Dictionary of Occupational Titles. That document is published by the Department of Labor. If the Department stops publishing that document, we have the right to use some other similar standard.

Part-Time The ability to work and earn between 40% and 80% of *insured earnings* during the *own occupation* period and between 40% and 60% of *insured earnings* after the *own occupation* period.

Plan Sponsor The employer, association, union, trustee, or other group to which this *plan* is issued.

Recurring Disability A later *disability* that: (a) is related to an earlier *disability* for which this *plan* paid benefits; and (b) meets the conditions described in "Recurring Disability."

Regular Care A person is being treated by, or in consultation with, a *doctor* at a frequency that is consistent with his or her condition. The requirement for *regular care* does not apply if he or she has reached his or her maximum point of recovery yet is still disabled under the terms of this *plan.*

CGP-3-LTD2K01-12.14 B380.0524

Rehabilitation Agreement A formal agreement between; (a) you; (b) us; and (c) your *employer,* if needed. It outlines the *rehabilitation program* in which you agree to take part.

Rehabilitation Program A program of work or job-related training for you that we approve in writing. Its aim is to restore your wage earning abilities.

Retirement Plan A defined benefit or defined contribution plan funded wholly or in part by the *employer's* deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans: (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans.

Retirement Plan **"retirement benefits"** are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits.* When such payments do not reduce the normal retirement amount, they are **"disability benefits."**

Sickness An illness or disease. Pregnancy is treated as a *sickness* under this *plan.*

We, Us, And Guardian The Guardian Life Insurance Company of America.

You The person insured by this *plan.*

CGP-3-LTD2K-12.15 B380.0135

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

Employee Coverage

Eligible Employees

To be eligible for *employee* coverage you must be an active *full-time employee.* And you must belong to a class of *employees* covered by this *plan.*

Other Conditions

If you must pay all or part of the cost of *employee* coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we consider you to be a late entrant.

If you initially waived dental coverage under this *plan* because you were covered under another group *plan,* and you now elect to enroll in the dental coverage under this *plan,* the Penalty for Late Entrants provision will not apply to you with regard to dental coverage provided your coverage under the other *plan* ends due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's *plan;* (c) divorce; (d) death of your spouse; or (e) termination of the other *plan.*

But you must enroll in the dental coverage under this *plan* within 30 days of the date that any of the events described above occur.

CGP-3-EC-90-1.0 B489.0122

When Your Coverage Starts

Employee benefits are scheduled to start on your effective date.

But you must be actively at work on a *full-time* basis on the scheduled effective date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on the date your insurance is scheduled to start, we will postpone your coverage until the date you return to active *full-time* work.

Sometimes, your effective date is not a regularly scheduled work day. But coverage will still start on that date if you were actively at work on a *full-time* basis on your last regularly scheduled work day.

CGP-3-EC-90-2.0 B489.0070

When Your Coverage Ends

Your coverage ends on the date your active *full-time* service ends for any reason, other than disability. Such reasons include death, retirement, layoff, leave of absence and the end of employment.

It also ends on the date you stop being a member of a class of *employees* eligible for insurance under this *plan,* or when this *plan* ends for all *employees.* And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time.

CGP-3-EC-90-3.0 B489.0087

Dependent Coverage

B200.0271

Eligible Dependents For Dependent Dental Benefits

An employee's eligible dependents are: (a) his or her legal spouse; and (b) each of his or her dependent children until the earliest of: (i) the child's 26th birthday; or (ii) December 31, two years after the loss of the child's dependent status under the Internal Revenue Code.

CGP-3-DEP-90-2.0 B489.0245

Adopted Children Step-Children And Foster Children

Your "unmarried dependent children" include your legally adopted children, foster children for whom you have filed petitions to adopt; and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted: (a) from the date the child is placed in your home for the purpose of adoption; or (b) in the case of a foster child, from the date you file a petition to adopt. We treat such children this way whether or not a final adoption order is ever issued.

Dependents Not Eligible

We exclude any dependent who is insured by this *plan* as an *employee*. And we exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.0 B489.0180

Handicapped Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the *plan,* such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached this coverage's age limit; (b) he or she became insured by this coverage before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on you for most of his or her support and maintenance.

But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year.

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0 B449.0042

Waiver Of Dental Late Entrants Penalty

If you initially waived dental coverage for your spouse or eligible dependent children under this plan because they were covered under another group plan, and you now elect to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan.

But you must enroll your spouse or eligible dependent children in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

In addition, the Penalty for Late Entrants provision for dental coverage will not apply to your spouse or eligible dependent children if: (a) you are under legal obligation to provide dental coverage due to a court-order; and (b) you enroll them in the dental coverage under this plan within 30 days of the issuance of the court-order.

CGP-3-DEP-90-5.0 B200.0749

When Dependent Coverage Starts

In order for your dependent coverage to begin you must already be insured for employee coverage or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this *plan,* the date your dependent coverage starts depends on when you elect to enroll your *initial dependents* and agree to make any required payments.

If you do this on or before your *eligibility date,* the dependent's coverage is scheduled to start on the later of your *eligibility date* and the date you become insured for employee coverage.

If you do this within the *enrollment period,* the coverage is scheduled to start on the later of the date you sign the enrollment form; and the date you become insured for employee coverage.

If you do this after the *enrollment period* ends, each of your *initial dependents* is a late entrant and is subject to any applicable late entrant penalties. The dependent's coverage is scheduled to start on the date you sign the enrollment form.

Once you have dependent coverage for your *initial dependents,* you must notify us when you acquire any new dependents and agree to make any additional payments required for their coverage.

If you do this within 31 days of the date the *newly acquired dependent* becomes eligible, the dependent's coverage will start on the date the dependent first becomes eligible. If you fail to notify us on time, the *newly acquired dependent,* when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant's coverage is scheduled to start on the date you sign the enrollment form.

CGP-3-DEP-90-6.0 B489.0060

Exception If a dependent, other than a newborn child, is confined to a *hospital* or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.

CGP-3-DEP-90-7.0 B200.0692

Newborn Children We cover your or a covered dependent's newborn child for dependent benefits, from the moment of birth if, within 31 days of the child's birth, you: (a) notify us of the birth; or (b) submit a claim for payment of benefits on behalf of the child.

If you enroll the newborn child more than 31 days after the child's birth, once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form.

CGP-3-DEP-90-8.0 B489.0014

When Dependent Coverage Ends Dependent coverage ends for all of your dependents when your coverage ends. But if you die while insured, we'll automatically continue dependent benefits for those of your dependents who were insured when you died. We'll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain *eligible dependents;* and (c) in the case of a spouse, the spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under this *plan's* "Federal Continuation Rights" provision, or under any other continuation provision of this *plan,* if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent coverage also ends for all of your dependents when you stop being a member of a class of *employees* eligible for such coverage. And it ends when this *plan* ends, or when dependent coverage is dropped from this *plan* for all *employees* or for an *employee's* class.

If you are required to pay all or part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he or she stops being an *eligible dependent.* This happens to a child at 12:01 a.m. on the date the child attains this coverage's age limit, when he or she marries, or when a step-child is no longer dependent on you for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment.

Read this *plan* carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.

CGP-3-DEP-90-9.0 B489.0048

CERTIFICATE AMENDMENT

This rider amends the "Dependent Coverage" provisions as follows:

An employee's domestic partner will be eligible for dental coverage under this plan. Coverage will be provided subject to all the terms of this plan and to the following limitations:

To qualify for such coverage, both the employee and his or her domestic partner must:

- be 18 years of age or older;
- be unmarried, constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- be financially interdependent which must be demonstrated by at least four of the following:
  a. ownership of a joint bank account;
  b. ownership of a joint credit account;
  c. evidence of a joint mortgage or lease;
  d. evidence of joint obligation on a loan;
  e. joint ownership of a residence;
  f. evidence of common household expenses such as utilities or telephone;
  g. execution of wills naming each other as executor and/or beneficiary;
  h. granting each other durable powers of attorney;
  i. granting each other health care powers of attorney;
  j. designation of each other as beneficiary under a retirement benefit account; or
  k. evidence of other joint financial responsibility.

The employee must complete a "Declaration of Domestic Partnership" attesting to the relationship.

The domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee's dependent children.

Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

And, the domestic partner and his or her children will be not eligible for:

a. survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section; or

b. continuation of dental coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

This rider is a part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-DMST-96 B210.0016

DENTAL HIGHLIGHTS

This page provides a quick guide to some of the Dental Expense Insurance *plan* features which people most often want to know about. But it's not a complete description of your Dental Expense Insurance *plan.* Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

- **PPO Benefit Year Cash Deductible for Non-Orthodontic Services**

  For Group I, II and III Services . . . . . None

- **Non-PPO Benefit Year Cash Deductible for Non-Orthodontic Services**

  For Group I Services . . . . . None

  For Group II and III Services . . . . . $50.00 for each covered person

CGP-3-DENT-HL-90 B497.1252

- **Payment Rates for Services Furnished by a Preferred Provider:**

  For Group I Services 100%
  For Group II Services 100%
  For Group III Services 60%

- **Payment Rates for Services Not Furnished by a Preferred Provider:**

  For Group I Services 100%
  For Group II Services 80%
  For Group III Services 50%

CGP-3-DENT-HL-90 B497.0088

- **Benefit Year Payment Limit for Non-Orthodontic Services**

  For Group I, II and III Services . . . . . Up to $1,000.00

Note: A covered person may be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit for Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Non-Orthodontic Services" for details.

CGP-3-DENT-HL-90 B497.1431

Once each year, during the group enrollment period, you may elect to enroll in one of the dental expense *plan* options offered by your employer. The group enrollment period is a time period agreed to by your employer and us. Coverage starts on the first day of the month that next follows the date of enrollment. You and your eligible dependents are not subject to late entrant penalties if they enroll during the group enrollment period.

Once each year, during a special election period you may select to transfer to another dental expense plan option offered by your employer. The special election period is a time period agreed to by your employer and us. Coverage under the new plan option starts of the first day of the month that follows election. Coverage under the former plan option ends on that date.

The group enrollment period and the special election periods are time periods agreed to by your employer and us. Such open enrollment period and special election period may occur during the same time period.

CGP-3-DENT-HLTS B497.2409

DENTAL EXPENSE INSURANCE

This insurance will pay many of a *covered person's* dental expenses. *We* pay benefits for covered charges incurred by a *covered person.* What *we* pay and terms for payment are explained below.

CGP-3-DG2000 B498.0007

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

This *plan* is designed to provide high quality dental care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek dental care from *dentists* and dental care facilities that are under contract with *Guardian's dental preferred provider organization (PPO),* which is called DentalGuard Preferred.

The dental PPO is made up of *preferred providers* in a covered person's geographic area. Use of the dental PPO is voluntary. A *covered person* may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers anytime.

This *plan* usually pays a higher level of benefits for covered treatment furnished by a *preferred provider.* Conversely, it usually pays less for covered treatment furnished by a *non-preferred provider.*

When an *employee* enrolls in this *plan,* he or she and his or her dependents receive a dental plan ID card and information about current *preferred providers.*

A *covered person* must present his or her ID card when he or she uses a *preferred provider.* Most *preferred providers* prepare necessary claim forms for the *covered person,* and submit the forms to *us.* We send the *covered person* an explanation of this *plan's* benefit payments, but any benefit payable by us is sent directly to the *preferred provider.*

What *we* pay is based on all of the terms of this *plan.* Please read this *plan* carefully for specific benefit levels, deductibles, *payment rates* and *payment limits.*

A *covered person* may call the Guardian at the number shown on his or her ID card should he or she have any questions about this *plan.*

CGP-3-DGY2K-PPO B498.0151

Covered Charges

If a *covered person* uses the services of a *preferred provider,* covered charges are the charges listed in the fee schedule the *preferred provider* has agreed to accept as payment in full, for the dental services listed in this *plan's* List of Covered Dental Services.

If a *covered person* uses the services of a *non-preferred provider,* covered charges are reasonable and customary charges for the dental services listed in this *plan's* List of Covered Dental Services.

To be covered by this *plan,* a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

We may use the professional review of a *dentist* to determine the appropriate benefit for a dental procedure or course of treatment.

By reasonable, *we* mean the charge is the *dentist's* usual charge for the service furnished. By customary, *we* mean the charge made for the given dental condition isn't more than the usual charge made by most other *dentists.* But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this *plan,* these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the *dentist* submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, we may only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred by a *covered person* while he or she is insured by this *plan.* A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other *dental prosthesis* is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. All other covered charges are incurred on the date the services are furnished. If a service is started while a *covered person* is insured, *we'll* only pay benefits for services which are completed within 31 days of the date his or her coverage under this *plan* ends.

Appeal And Grievance Process

Definitions

Adverse decision means a utilization review determination that a proposed or delivered dental service which would otherwise be covered, is not or was not medically necessary, appropriate or efficient, resulting in non- coverage of the service. An adverse decision does not include a decision about a covered person's status as an insured.

Grievance means a written protest filed by a covered person or his or her dentist regarding an adverse decision.

Emergency means a situation where a covered person's dentist believes that the services are necessary to treat a condition that without immediate attention would seriously jeopardize: (a) the life or health of the covered person; or (b) his or her ability to regain maximum function. Note: Covered persons who require emergency care may call the local pre- hospital emergency medical service system by dialing 911, or its local equivalent. No covered person will be denied coverage as a result of such use of emergency care.

Appeals and Grievances

Claim Review If a claim is denied in whole or in part, a covered person or his or her dentist may appeal by writing to us at the address shown below.

The Guardian Life Insurance Company of America
Grievance Department
PO Box 2457
Spokane, WA 99210-2457
fax#: 509-468-6399

A decision and written notice will be completed within 30 working days of receipt of all documentation necessary to complete our review of the appeal. Written notice will be sent to the covered person and his or her dentist, if the claim is assigned or the dentist is a preferred provider. If the claim is not assigned, or the dentist is not a preferred provider, we will send notice to the covered person only.

Utilization Review Within 30 working days of receipt of all necessary information, we will send written notice of an initial adverse decision, via US Mail, to the covered person and his or her dentist, if the claim is assigned or the dentist is a preferred provider. If the claim is not assigned, or the dentist is not a preferred provider, we will send notice to the covered person only. The notice will state the specific factual basis for the denial and specific criteria the adverse decision was based on.

Only a licensed dentist will render an adverse decision. In the case of an emergency, a covered person or his or her dentist may file an expedited request for a utilization review decision.

A covered person or his or her dentist may initiate a grievance of an adverse decision by writing to:

The Guardian Life Insurance Company of America
Grievance Department
PO Box 2457
Spokane, WA 99210-2457
fax#: 509-468-6399

A decision regarding a grievance of an adverse decision and written notice will be completed within 30 working days of receipt of all documentation necessary to complete the review. The notice of the decision will be sent, via US Mail, to the covered person and his or her dentist, if the claim is assigned or the dentist is a preferred provider. If the claim is not assigned, or the dentist is not a preferred provider, we will send notice to the covered person only. The notice will include the factual basis and specific criteria the decision was based on.

If sufficient information to complete the grievance process is not received with the filing, the covered person and his or her dentist will be notified, via US Mail, what information is required. If the information requested to complete our review is not received, the covered person and his or her dentist will be notified, via US Mail, that the grievance has been denied. Upon receipt of the requested information Guardian will reopen the grievance.

A grievance will be reviewed by a different dentist than the one who rendered the initial adverse decision. That dentist will be licensed in the same or similar specialty as the service being reviewed.

In the case of an emergency request, the covered person and his or her dentist will receive oral notification of the decision, via telephone, within 24 hours of receipt of all necessary documentation to review the request. Written notice will be sent, via US Mail, within one working day of notice of the oral decision.

Accessibility Guardian's Customer Response Unit Member Specialists are accessible by toll free number, 1-800-541-7846, not less than 40 hours per week during normal business hours to provide information and allow responses to phone requests.

The Customer Response Unit, Member Specialists are available from 6:00 a.m. to 6:00 p.m. Pacific Time. Telephone calls received during other than normal business hours will be provided instructions.

Guardian offers onsite interpreters for Spanish speaking insureds. An interpretation service is utilized for all other languages.

CGP-3-R-DGRV-MA-06 B498.2759

Alternate Treatment

If more than one type of service can be used to treat a dental condition, *we* have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by *us.* For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture. In the case of a composite filling on a *posterior tooth*, the benefit will be based on the corresponding amalgam filling benefit.

Proof Of Claim

So that *we* may pay benefits accurately, the *covered person* or his or her *dentist* must provide *us* with information that is acceptable to *us.* This information may, at *our* discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document *proof of claim* and support the necessity of the proposed treatment. If *we* don't receive the necessary information, *we* may pay no benefits, or minimum benefits. However, if *we* receive the necessary information within 15 months of the date of service, *we* will redetermine the *covered person's* benefits based on the new information.

Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the *covered person's dentist* should send us a treatment plan before he or she starts. This must be done on a form acceptable to *Guardian.* The treatment plan must include: (a) a list of the services to be done, using the American Dental Association Nomenclature and codes; (b) the itemized cost of each service; and (c) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to *us.*

We review the treatment plan and estimate what we will pay. We will send the estimate to the covered person and/or the covered person's dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to us, we have the right to base our benefit payments on treatment appropriate to the covered person's condition using accepted standards of dental practice.

The covered person and his or her dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the covered person, and his or her dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the covered person is insured; and (b) the deductible, payment rate and payment limits provisions, and all of the other terms of this plan.

Pre-Treatment Review (Cont.)

Emergency treatment, oral examinations, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We won't deny or reduce benefits if pre-treatment review is not done. But what we pay will be based on the availability and submission of proof of claim.

CGP-3-DGY2K-PTR B498.0004

Benefits From Other Sources

Other plans may furnish benefits similar to the benefits provided by this *plan.* For instance, you may be covered by this *plan* and a similar plan through your spouse's employer. You may also be covered by this *plan* and a medical plan. In such instances, we coordinate *our* benefits with the benefits from that other plan. *We* do this so that no one gets more in benefits than the charges he or she incurs. Read "Coordination of Benefits" to see how this works.

CGP-3-DGY2K-OS B498.0005

The Benefit Provision - Qualifying For Benefits

CGP-3-DGY2K-BEN B498.0072

Penalty For Late Entrants

During the first 6 months that a late entrant is covered by this *plan, we* won't pay for the following services:

- All Group II Services.

During the first 12 months a late entrant is covered by this *plan, we* won't pay for the following services:

- All Group III Services.

Charges for the services we don't cover under this provision are not considered to be covered charges under this *plan,* and therefore can't be used to meet this *plan's* deductibles.

We don't apply a late entrant penalty to covered charges incurred for services needed solely due to an *injury* suffered by a *covered person* while insured by this *plan.*

A late entrant is a person who: (a) becomes covered by this dental *plan* more than 31 days after he or she is eligible; or (b) becomes covered again, after his or her coverage lapsed because he or she did not make required payments.

CGP-3-DGY2K-LE B498.0232

How We Pay Benefits For Group I, II And III Non-Orthodontic Services

There is no deductible for Group I services and for Group II and III services provided by a *preferred provider. We* pay for all Group I and for Group II and III PPO covered charges at the applicable *payment rate.*

A *benefit year* deductible of $50.00 applies to Group II and III services provided by a *non-preferred provider.* Each *covered person* must have covered charges from these service groups which exceed the applicable deductible before *we* pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

Once a *covered person* meets the deductible, *we* pay for his or her Group II and III Non-PPO covered charges above that amount at the applicable *payment rate* for the rest of that *benefit year.*

CGP-3-DGY2K-BP B498.0439

All covered charges must be incurred while insured. And we limit what we pay each benefit year to $1,000.00.

CGP-3-DGY2K-BP B498.0192

The Benefit Provision - Qualifying For Benefits

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Group I, II and III Services" for details.

CGP-3-DG-ROLL-04-2.1 B498.2041

Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, as follows:

If a *covered person* submits at least one claim for covered charges during a *benefit year* and, in that *benefit year,* receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the *Rollover Threshold,* he or she may be entitled to a Reward.

Note: If all of the benefits that a *covered person* receives in a *benefit year* are for services provided by a *preferred provider,* he or she may be entitled to a greater *Reward* than if any of the benefits are for services of a *non-preferred provider.*

Rewards can accrue and are stored in the *covered person's Bank.* If a *covered person* reaches his or her *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, we pay benefits up to the amount stored in the *covered person's Bank.* The amount of *Reward* stored in the *Bank* may not be greater than the *Bank Maximum.*

A *covered person's Bank* may be eliminated, and the accrued *Reward* lost, if he or she has a break in coverage of any length of time, for any reason.

The amounts of this *plan's Rollover Threshold, Reward,* and *Bank Maximum* are:

- *Rollover Threshold* $500.00
- *Reward* (if all benefits are for services provided by a *preferred provider)* $350.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider)* $250.00
- *Bank Maximum* $1,000.00

If this *plan's* dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full *benefit year.* And, if the effective date of a *covered person's* dental coverage is in October, November or December, this rollover provision will not apply to the covered person until January 1 of the next full *benefit year.* In either case:

- only claims incurred on or after January 1 will count toward the *Rollover Threshold;* and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

If charges for any dental services are not payable for a *covered person* for a period set forth in the provision of this *plan* called Penalty for Late Entrants and Waiting Periods for Certain Services, this rollover provision will not apply to the *covered person* until the end of such period. And, if such period ends within the three months prior to the start of this plan's next *benefit year,* this rollover provision will not apply to the *covered person* until the next *benefit year,* and:

- only claims incurred on or after the start of the next *benefit year* will count toward the *Rollover Threshold;* and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

Definitions of terms used in this provision:

"Bank" means the amount of a *covered person's* accrued *Reward* .

"Bank Maximum" means the maximum amount of *Reward* that a *covered person* can store in his or her *Bank.*

"Reward" means the dollar amount which may be added to a *covered person's Bank* when he or she receives benefits in a *benefit year* that do not exceed the *Rollover Threshold.*

"Rollover Threshold" means the maximum amount of benefits that a *covered person* can receive during a *benefit year* and still be entitled to receive a *Reward.*

Non-Orthodontic Family Deductible Limit

A *covered family* must meet no more than three individual *benefit year* deductibles in any *benefit year.* Once this happens, *we* pay benefits for covered charges incurred by any *covered person* in that *covered family,* at the applicable *payment rate* for the rest of that *benefit year.* The charges must be incurred while the person is insured. What *we* pay is based on this *plan's payment limits* and to all of the terms of this *plan.*

CGP-3-DGY2K-FL B498.0073

Payment Rates

Benefits for covered charges are paid at the following *payment rates:*

- Benefits for Group I Services performed by a *preferred provider* 100%
- Benefits for Group I Services performed by a *non-preferred provider* 100%
- Benefits for Group II Services performed by a *preferred provider* 100%
- Benefits for Group II Services performed by a *non-preferred provider* 80%
- Benefits for Group III Services performed by a *preferred provider* 60%
- Benefits for Group III Services performed by a *non-preferred provider* 50%

CGP-3-DGY2K-PR B498.0078

After This Insurance Ends

We don't pay for charges incurred after a *covered person's* insurance ends. But, subject to all of the other terms of this *plan, we'll* pay for the following if the procedure is finished in the 31 days after a *covered person's* insurance under this *plan* ends: (a) a bridge or cast restoration, if the tooth or teeth are prepared before the *covered person's* insurance ends; (b) any other *dental prosthesis,* if the master impression is made before the *covered person's* insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the *covered person's* insurance ends.

CGP-3-DGY2K-END B498.0234

Special Limitations

CGP-3-DGY2K-LMT B498.0138

Teeth Lost, Extracted Or Missing Before A Covered Person Becomes Covered By This Plan

A *covered person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this *plan. We* won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan.*

CGP-3-DGY2K-TL B498.0133

If This Plan Replaces The Prior Plan

This *plan* may be replacing the *prior plan* you had with another insurer. If a *covered person* was insured by the *prior plan* and is covered by this *plan* on its effective date, the following provisions apply to such *covered person.*

- **Teeth Extracted While Insured By The Prior Plan** - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a *covered person's dental prosthesis* which replaces teeth: (a) that were extracted while the *covered person* was insured by the *prior plan;* and (b) for which extraction benefits were paid by the *prior plan.*
- **Deductible Credit** - In the first *benefit year* of this *plan,* we reduce a *covered person's* deductibles required under this *plan,* by the amount of covered charges applied against the *prior plan's* deductible. The *covered person* must give us proof of the amount of the *prior plan's* deductible which he or she has satisfied.
- ***Benefit Year* Non-Orthodontic Payment Limit Credit** - In the first *benefit year* of this *plan,* we reduce a *covered person's benefit year payment limits* by the amounts paid or payable under the *prior plan.* The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.

CGP-3-DGY2K-PP B498.0131

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan.*
- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.

- Any restoration, procedure, *appliance* or *prosthetic device* used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment;* (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this *plan.*
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment.*
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis* or the fabrication of a spare *appliance* or *dental prosthesis.*
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Pulp vitality tests or caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances* except interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan.*
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis;* (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.
- Replacing an existing *appliance* or *dental prosthesis* with a like or un-like *appliance* or *dental prosthesis;* unless (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.

- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury;* or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- *Orthodontic treatment,* unless the benefit provision provides specific benefits for *orthodontic treatment.*

CGP-3-DGY2K-EXCH B498.2127

List of Covered Dental Services

The services covered by this *plan* are named in this list. Each service on this list has been placed in one of three groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services.

All covered dental services must be furnished by or under the direct supervision of a *dentist.* And they must be usual and necessary treatment for a dental condition.

CGP-3-DNTL-90-13 B490.0148

Prophylaxis And Fluorides

Prophylaxis - limited to a total of 1 prophylaxis or periodontal maintenance procedure (considered under "Periodontal Services") in any 6 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition - covered once in 12 months, and only when the additional prophylaxis is recommended by the dentist and is a result of a medical condition as verified in writing by the patient's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application - limited to 1 treatment(s) in any 6 consecutive month period.

Office Visits, Evaluations And Examination

Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 1 in any 6 consecutive month period.

Emergency or problem focused oral evaluation - limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed in the same visit.

After hours office visit or emergency palliative treatment and other non-routine, unscheduled visits. Limited to a total of 1 in a 6 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the same visit.

CGP-3-DNTL-90-14 B498.4803

Space Maintainers

Space Maintainers - limited to *covered persons* under age 16 and limited to initial *appliance* only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral
- Fixed - bilateral
- Removable - bilateral
- Removable - unilateral

Recementation of space maintainer performed more than 12 months after the initial insertion

Fixed And Removable Appliances

Fixed and Removable Appliances To Inhibit Thumbsucking - limited to *covered persons* under age 14 and limited to initial *appliance* only. Allowance includes all adjustments in the first 6 months after insertion.

CGP-3-DNTL-90-14 B498.0164

Group I - Preventive Dental Services (Cont.)
(Non-Orthodontic)

Radiographs Allowance includes evaluation and diagnosis.
Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 60 consecutive month period.

Full mouth series, of at least 14 films including bitewings
Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:

Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal films - single films

CGP-3-DNTL-90-14 B498.0165

Dental Sealants Dental Sealants - permanent molar teeth only - Topical application of sealants is limited to the unrestored, permanent molar teeth of *covered persons* under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

CGP-3-DNTL-90-14 B498.0166

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic Services Allowance includes examination and diagnosis.

Consultations - Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each *covered dental specialty* in any 12 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic Services: Allowance includes examination and diagnosis.

Diagnostic casts - when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays or onlays.

Histopathologic examinations when performed in conjunction with a tooth related biopsy.

Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - limited to one test in any 24 consecutive month period for covered persons age 40 and older.

Restorative Services Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing amalgam and resin restorations will only be considered for payment if at least 12 months have passed since the previous restoration was placed if the *covered person* is under age 19, and 36 months if the *covered person* is age 19 and older. Also see the "Major Restorative Services" section.

Amalgam restorations - Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations - limited to *anterior teeth* only. Coverage for resins on *posterior teeth* is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic. Restorations that do not involve the incisal edge are considered a single surface filling.

Silicate cement, per restoration
Composite resin

Stainless steel crown, prefabricated resin crown, and resin based composite crown - limited to once per tooth in any 24 consecutive month period. Stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth, covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

CGP-3-DNTL-90-15- B498.2764

Crown And Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

Crown and bridge repairs - allowance based on the extent and nature of damage and the type of material involved.

Recementation, limited to recementations performed more than 12 months after the initial insertion.

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

Denture repairs - Allowance based on the extent and nature of damage and on the type of materials involved.

Denture repairs, metal
Denture repairs, acrylic
Denture repair, no teeth damaged
Denture repair, replace one or more broken teeth
Replacing one or more broken teeth, no other damage

Denture rebase, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the *dentist* who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture relines done within 12 months are considered to be part of the denture placement when the reline is done by the *dentist* who furnished the denture. Limited to reline done more than 12 consecutive months after a denture rebase or the insertion of the denture.

Denture adjustments - Denture adjustments done within 6 months are considered to be part of the denture placement when the adjustment is done by the *dentist* who furnished the denture. Limited to adjustments that are done more than 6 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning - Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the *dentist* who furnished the denture. Limited to a maximum of 1 treatment, per arch, in any 12 consecutive month period.

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Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.
- Pulp capping, direct
- Pulp capping, indirect - includes sedative filling.

Vital pulpotomy, only when root canal therapy is not the definitive treatment
Gross pulpal debridement
Pulpal therapy, limited to primary teeth only
Root Canal Treatment
- Root canal therapy
- Root canal retreatment, limited to once per tooth, per lifetime
- Treatment of root canal obstruction, no-surgical access
- Incomplete endodontic therapy, inoperable or fractured tooth
- Internal root repair of perforation defects

Other Endodontic Services
- Apexification, limited to a maximum of three visits
- Apicoectomy, limited to once per root, per lifetime
- Root amputation, limited to once per root, per lifetime
- Retrograde filling, limited to once per root, per lifetime
- Hemisection, including any root removal, once per tooth

CGP-3-DNTL-90-15.0 B498.0201

Periodontal Services

Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Periodontal maintenance procedure - limited to a total of 1 prophylaxis or periodontal maintenance procedure(s) in any 6 consecutive month period. Allowance includes periodontal pocket charting, scaling and polishing. (Also see Prophylaxis under "Preventive Services") Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).

Scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement - limited to once in any 36 consecutive month period. Considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

CGP-3-DNTL-90-15.0 B498.0202

Periodontal Surgery Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months.

Gingivectomy, per tooth (less than 3 teeth)
Crown lengthening - hard tissue

The following treatment is limited to a total of one of the following once per quadrant, in any 36 consecutive months.

Gingivectomy or gingivoplasty, per quadrant
Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant
Gingival flap procedure, including scaling and root planing, per quadrant
Distal or proximal wedge, not in conjunction with osseous surgery
Surgical revision procedure, per tooth

The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months.

Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

The following treatment is limited to a total of one of the following, once per area or tooth, per lifetime.

Guided tissue regeneration, resorbable barrier or nonresorbable barrier
Bone replacement grafts, when the tooth is present

Periodontal surgery related

Limited occlusal adjustment - limited to a total of two visits, covered only when done within a 6 consecutive month period after covered scaling and root planing or osseous surgery. Must have radiographic evidence of vertical defect or widened periodontal ligament space.

Occlusal guards, covered only when done within a 6 consecutive month period after osseous surgery, and limited to one per lifetime

CGP-3-DNTL-90-15.0 B498.0203

Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care.

Uncomplicated extraction, one or more teeth
Root removal non-surgical extraction of exposed roots

Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Surgical removal of erupted teeth, involving tissue flap and bone removal
Surgical removal of residual tooth roots
Surgical removal of impacted teeth

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Alveoloplasty, per quadrant
Removal of exostosis, per site
Incision and drainage of abscess
Frenulectomy, Frenectomy, Frenotomy
Biopsy and examination of tooth related oral tissue
Surgical exposure of impacted or unerupted tooth to aid eruption
Excision of tooth related tumors, cysts and neoplasms
Excision or destruction of tooth related lesion(s)
Excision of hyperplastic tissue
Excision of pericoronal gingiva, per tooth
Oroantral fistula closure
Sialolithotomy
Sialodochoplasty
Closure of salivary fistula
Excision of salivary gland
Maxillary sinusotomy for removal of tooth fragment or foreign body
Vestibuloplasty

CGP-3-DNTL-90-15.0 B498.1124

Other Services General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under the "Other Oral Surgical Procedures" section of this *plan.*

Injectable antibiotics needed solely for treatment of a dental condition.

CGP-3-DNTL-90-15 B498.0206

Major Restorative Services

Crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or *injury,* and only when the tooth cannot be restored with amalgam or composite filling material. Post and cores are covered only when needed due to decay or *injury.* Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also see the "Basic Restorative Services" section.

Single Crowns
- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal (other than stainless steel)
- 3/4 cast metal crowns
- 3/4 porcelain crowns

Inlays
Onlays, including inlay
Labial veneers
Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth
- Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth
- Crown or core buildup, including pins

Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic, when done in conjunction with a covered surgical placement of an implant, on the same tooth.
- Abutment supported crown
- Implant supported crown
- Abutment supported retainer for fixed partial denture
- Implant supported retainer for fixed partial denture
- Implant/abutment supported removable denture for completely edentulous arch
- Implant/abutment supported removable denture for partially edentulous arch
- Implant/abutment supported fixed denture for completely edentulous arch
- Implant/abutment supported fixed denture for partially edentulous arch
- Dental implant supported connecting bar
- Prefabricated abutment
- Custom abutment

Implant services - Allowance includes the treatment plan, local anesthetic and post-surgical care. Limited to the replacement of permanent teeth only. The number of implants we cover is limited to the number of teeth extracted while insured under this plan.

Surgical placement of implant body, endosteal implant
Surgical placement, eposteal implant
Surgical placement transosteal implant

Other Implant services

Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, per lifetime
Radiographic/surgical implant index - limited to once per arch in any 24 month period
Repair implant supported prosthesis
Repair implant abutment
Implant removal

CGP-3-DNTL-90-16 B498.1129

Prosthodontic Services

Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only.

Fixed bridges - Each abutment and each pontic makes up a unit in a bridge

Bridge abutments - See inlays, onlays and crowns under "Major Restorative Services"

Bridge Pontics
Resin with metal
Porcelain
Porcelain with metal
Full cast metal

Dentures - Allowance includes all adjustments and repairs done by the *dentist* furnishing the denture in the first 6 consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent *appliance.*

Complete or Immediate dentures, upper or lower

Partial dentures - Allowance includes base, clasps, rests and teeth

Upper, resin base, including any conventional clasps, rests and teeth

Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Lower, resin base, including any conventional clasps, rests and teeth

Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Interim partial denture (stayplate), upper or lower, covered on *anterior teeth* only

Removable unilateral partial, one piece cast metal, including clasps and teeth

Simple stress breakers, per unit

DISCOUNT - THIS IS NOT INSURANCE

Discounts on Dental Services Not Covered By This Plan

A covered person under this plan can receive discounts on certain services not covered by this plan, as described below, if:

(a) he or she receives services or supplies from a dentist that is under contract with our DentalGuard Preferred Provider Organization (PPO) network; and

(b) the service or supply is on the fee schedule the dentist has agreed to accept as payment in full as a member of the PPO network.

The services described in this provision are not covered by this plan. The covered person must pay the entire discounted fee directly to the dentist. There is no need to file a claim.

When a person is no longer covered by this plan, access to the network discounts ends.

B499.0077

Discounts on Services Not Covered Due To Contractual Provisions

If a covered person receives dental services from a dentist who is under contract with Guardian's DentalGuard Preferred PPO, such services will be provided at the discounted fee the dentist agreed to accept as payment in full as a member of our DentalGuard Preferred PPO network, even if such services are not covered by the plan due to:

- Meeting the plan's benefit year payment limit provision;
- Frequency limitations; or
- Plan exclusions.

B499.0078

Discounts on Orthodontic Services

If a covered person receives any of the following orthodontic dental services from an orthodontist who is under contract with Guardian's DentalGuard Preferred PPO network, such services will be provided at the discounted fee the dentist has agreed to accept as payment in full as a member of such network. The services are:

- Pre-orthodontic treatment visit
- Limited orthodontic treatment
- Interceptive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;

- Comprehensive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits
- Periodic comprehensive orthodontic treatment visit (as part of a contract);
- Orthodontic retention, including fixed and removable initial appliances and related visits.

Discounted fees are not available for:

- Incremental charges for orthodontic appliances made with clear, ceramic, white, lingual brackets or other optional materials;
- Procedures, appliances or devices to guide minor tooth movement or to correct harmful habits;
- Retreatment of orthodontic cases, or changes in orthodontic treatment needed due to an accident;
- Extractions performed solely to facilitate orthodontic treatment;
- Orthognathic surgery and associated incremental charges;
- Replacement of lost or broken retainers.

B499.0081

VISION DISCOUNT PROGRAM

Employee Vision Discount Program

An employee's eligibility for this vision discount program is contingent upon his or her eligibility for dental coverage under this plan.

If an employee is covered for dental coverage under this plan, he or she is eligible for this vision discount program.

If an employee is not covered under this plan's dental coverage, he or she is not eligible for this vision discount program.

An employee's participation in this vision discount program starts on the later of: (a) the effective date of this program; or (b) the date he or she becomes covered for dental benefits under this plan.

An employee's participation in this vision discount program ends on the earlier of: (a) the date this program ends; or (b) the date he or she is no longer covered for dental benefits under this plan.

CGP-3-EC-90-1.0 B506.0002

Dependent Vision Discount Program

An employee's covered dependent's eligibility for this vision discount program is contingent upon his or her eligibility for dental coverage under this plan.

If a dependent is covered for dental coverage under this plan, he or she is eligible for this vision discount program.

If the dependent is not covered under this plan's dental coverage, he or she is not eligible for this vision discount program.

A dependent's participation in this vision discount program starts on the later of: (a) the effective date of this program; or (b) the date he or she becomes covered for dental benefits under this plan.

The dependent's participation in this vision discount program ends on the earlier of: (a) the date this program ends; or (b) the date he or she is no longer covered for dental benefits under this plan.

CGP-3-DEP-90-1.0 B506.0003

This Is Not Insurance

Discounts on Vision Services and Supplies

A member of this program can receive discounts on vision care services or supplies from a vision provider who is under contract with Vision Service Plan's (VSP's) network, as described below. Discounts are not available from providers who are not members of VSP's network.

The member must pay the entire discounted fee directly to the VSP network doctor. There is no need to file a claim.

A member must make an appointment with a VSP network doctor. To find a VSP network doctor, the member can visit www.vsp.com or call 1-800-877-7195.

When a person is no longer a member of this program, access to the network discounts ends.

The discounts provided by this program are as follows:

Eye Exams - 20% off the VSP doctor's usual charge.

Glasses and Lenses: Discounts are given for an unlimited number of glasses or contact lens professional services visits, as long as the VSP network doctor has provided an eye exam to the member within the last 12 months.

- Standard lenses - 20% off the VSP doctor's usual charge, when a complete set of prescription glasses is purchased.
- Lens options - 20% off the VSP doctor's usual charge for all lens options, such as tints and coatings.
- Frames - 20% off the VSP doctor's usual charge when a complete set of prescription glasses is purchased.
- Elective contact lenses - 15% off the VSP doctor's usual charge for professional services. The lenses are not discounted.

VSP network doctors are not required to extend a discount if they have not provided an eye exam to the patient within the last 12 months.

No discounts will be given for:

- sundry items such as lens cleaners and solutions,
- artistically painted lenses,
- additional office visits associated with contact lens pathology,
- contact lens modification, polishing or cleaning,
- orthoptics or vision training and any associated supplemental testing,
- plano lenses,
- expenses associated with securing materials such as lenses and frames,
- medical or surgical treatment of the eyes except as described in the "Laser Surgery" section below.

Laser Surgery: The discount program provides access to a network of laser surgery centers where members and their dependents can obtain vision laser surgery at a discounted fee. Members save an average of 15% off the laser surgeon's usual charge. And, if the laser center is offering a temporary price reduction, the member will receive 5% off the promotional price if it is less than the usual discounted price.

No one will have to pay more than $1,800 per eye for laser-assisted in-situ keratomileusis (LASIK), and $1,500 per eye for photorefractive keratectomy (PRK), two of the most common procedures.

If a member or a member's dependent is interested in the discount program, he or she must schedule a screening and consultation with a VSP doctor to discuss whether vision laser surgery is an appropriate procedure.

If the member or dependent decides to proceed with the surgery, the doctor will refer him or her to a VSP laser surgeon for further evaluation.

The laser center's fee includes the fee for the initial screening and consultation, the surgery itself and all post-operative care.

If the doctor determines that the member or dependent is an appropriate candidate for the laser surgery, but he or she does not have the surgery performed, he or she must pay the fee for the screening and consultation directly to the VSP network doctor. If the doctor determines that the

enrollee or dependent is not an appropriate candidate for laser surgery, no fee is charged for the consultation.

B506.0004

COORDINATION OF BENEFITS

Important Notice This section applies to all group health benefits under this plan; except prescription drug and vision coverage, if any. It does not apply to any death, dismemberment, or loss of income benefits that may be provided under this plan.

Purpose When a covered person has health care coverage under more than one plan, this section allows this plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

Definitions

Allowable Expense This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. When a plan uses capitation as the method of paying its providers of services, the reasonable cash value of such services will be used as the basis of determining payment.

An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

(1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.

(2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.

(3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.

(4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

Claim This term means a request that benefits of a plan be provided or paid.

Claim Determination Period This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

Coordination Of Benefits This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contracts This term means contracts: (a) which are not available to the general public; and (b) can be obtained and maintained only because of membership in or connection with a particular organization or group.

Hospital Indemnity Benefits This term means benefits provided during hospital confinement on other than an expense incurred basis.

Plan This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group subscriber contracts; (2) uninsured arrangements of group coverage; (3) group coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans; (4) group-type contracts; (5) amounts of group or group-type hospital indemnity benefits in excess of $100.00 per day; (6) medical benefits under automobile contracts to the extent permitted by law; and (7) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) nongroup coverage, except group-type contracts, hospital indemnity benefits, and medical benefits under automobile contracts, as shown above; (b) amounts of group or group-type hospital indemnity benefits of $100.00 or less per day; (c) student accident type coverage, Qualifying Student Health Insurance Programs, or other student health plans when designated as "excess only" or "always secondary plan"; or (d) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan This term means a plan that is not a primary plan.

This Plan This term means the group health benefits, except prescription drug and vision coverage, if any, provided under this group plan.

Order Of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the following rules that applies is the rule to use.

Non-Dependent Or Dependent The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan The order of benefit determination when a child is covered by more than one plan is:

(1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.

(2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

(3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; and (c) the plan of the noncustodial parent.

Active Or Inactive Employee The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length Of Coverage The plan that covered the person longer is primary.

Other If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this plan will not pay more than it would have had it been the primary plan.

Effect On The Benefits Of This Plan

When This Plan Is Primary When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan Is Secondary When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility Of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Right Of Recovery

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

Anterior Teeth means the incisor and cuspid teeth. The teeth are located in front of the bicuspids (pre-molars).

CGP-3-GLOSS-90 B750.0664

Appliance means any dental device other than a *dental prosthesis.*

CGP-3-GLOSS-90 B750.0665

Benefit Year means a 12 month period which starts on January 1st and ends on December 31st of each year.

CGP-3-GLOSS-90 B750.0666

Covered Dental Specialty means any group of procedures which falls under one of the following categories, whether performed by a specialist *dentist* or a general *dentist:* restorative/prosthodontic services; endodontic services, periodontic services, oral surgery and pedodontics.

CGP-3-GLOSS-90 B750.0667

Covered Family means an employee and those of his or her dependents who are covered by this *plan.*

CGP-3-GLOSS-90 B750.0668

Covered Person means an employee or any of his or her covered dependents.

CGP-3-GLOSS-90 B750.0669

Dental Prosthesis means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.

CGP-3-GLOSS-90 B750.0670

Dentist means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this *plan.*

CGP-3-GLOSS-90 B750.0671

Eligibility Date for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0003

Eligible Dependent is defined in the provision entitled "Dependent Coverage."

CGP-3-GLOSS-90 B750.0015

Emergency Treatment means bona fide emergency services which: (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this *plan.*

CGP-3-GLOSS-90 B750.0672

Employee means a person who works for the *employer* at the *employer's* place of business, and whose income is reported for tax purposes using a W-2 form.

CGP-3-GLOSS-90 B750.0006

Employer means PEAK MANUFACTURING .

CGP-3-GLOSS-90 B900.0051

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0004

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 30 hours per week), at his *employer's* place of business.

CGP-3-GLOSS-90 B750.0229

Initial Dependents means those *eligible dependents* you have at the time you first become eligible for *employee* coverage. If at this time you do not have any *eligible dependents,* but you later acquire them, the first *eligible dependents* you acquire are your *initial dependents.*

CGP-3-GLOSS-90 B900.0006

Injury means all damage to a *covered person's* mouth due to an accident which occurred while he or she is covered by this *plan,* and all complications arising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *dental prostheses* which results solely from chewing or biting food or other substances.

CGP-3-GLOSS-90 B750.0673

Newly Acquired Dependent means an *eligible dependent* you acquire after you already have coverage in force for *initial dependents.*

CGP-3-GLOSS-90 B900.0008

Non-Preferred Provider means a *dentist* or dental care facility that is not under contract with DentalGuard Preferred as a *preferred provider.*

CGP-3-GLOSS-90 B750.0674

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances.* it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits. This *plan* does not pay benefits for *orthodontic treatment.*

CGP-3-GLOSS-90 B750.0685

Payment Limit means the maximum amount this *plan* pays for covered services during either a *benefit year* or a *covered person's* lifetime, as applicable.

CGP-3-GLOSS-90 B750.0676

Payment Rate means the percentage rate that this *plan* pays for covered services.

CGP-3-GLOSS-90 B750.0677

Posterior Teeth means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

CGP-3-GLOSS-90 B750.0679

Plan means the Guardian group dental plan purchased by the planholder.

CGP-3-GLOSS-90 B750.0678

Preferred Provider means a *dentist* or dental care facility that is under contract with DentalGuard Preferred as a preferred provider.

CGP-3-GLOSS-90 B750.0680

Prior Plan means the planholder's plan or policy of group dental insurance which was in force immediately prior to this *plan.* To be considered a prior plan, this *plan* must start immediately after the prior coverage ends.

CGP-3-GLOSS-90 B750.0681

Proof Of Claim means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

CGP-3-GLOSS-90 B750.0682

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

CGP-3-GLOSS-90 B900.0010

We, Us, Our And Guardian mean The Guardian Life Insurance Company of America.

CGP-3-GLOSS-90 B750.0683

STATEMENT OF ERISA RIGHTS

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement Of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A "qualified medical child support order" is a judgment or decree issued by a state court that requires a group medical plan to provide coverage to the named dependent child(ren) of an employee pursuant to a state domestic relations order. For the order to be qualified it must include:

- The name of the group health plan to which it applies.
- The name and last known address of the employee and the child(ren).
- A reasonable description of the type of coverage or benefits to be provided by the plan to the child(ren).
- The time period to which the order applies.

A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

Note: A QMCSO cannot require a group health plan to provide any type or form of benefit or option not otherwise available under the plan except to the extent necessary to meet medical child support laws described in Section 90 of the Social Security Act.

If you have questions about this statement, see the plan administrator.

The Guardian's Responsibilities

CGP-3 B800.0048

The dental expense benefits provided by this plan are guaranteed by a policy of insurance issued by The Guardian. The Guardian also supplies administrative services, such as claims services, including the payment of claims, preparation of employee certificates of insurance, and changes to such certificates.

CGP-3 B800.0053

The Guardian is located at 7 Hanover Square, New York, New York 10004.

CGP-3 B800.0049

Disability And Group Health Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the *plan* with respect to claims. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of the Employee Retirement Income Security Act of 1974 ("ERISA")

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit. A failure to cover an item or

service: (a) due to the application of any utilization review; or (b) because the item or service is determined to be experimental or investigational, or not medically necessary or appropriate, is also considered an adverse determination.

"Group Health Benefits" means any dental, out-of-network point-of-service medical, major medical, vision care or prescription drug coverages which are a part of this plan.

"Pre-service claim" means a claim for a medical care benefit with respect to which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of receipt of care.

"Post-service claim" means a claim for payment for medical care that already has been provided.

"Urgent care claim" means a claim for medical care or treatment where making a non- urgent care decision: (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care.

Note: Any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care will be treated as an urgent care claim for purposes of this section.

Timing For Initial Benefit Determination

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Disability Benefits

Guardian will provide a benefit determination not later than 45 days after the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 45 days after receipt of the claim.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Group Health Benefits

Urgent Care Claims. Guardian will make a benefit determination within 72 hours after receipt of an urgent care claim.

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 24 hours after receipt of the claim. The claimant will be given not less than 48 hours to provide the specified information.

Guardian will notify the claimant of the benefit determination as soon as possible but not later than the earlier of:

- the date the requested information is received; or
- the end of the period given to the claimant to provide the specified additional information.

The required notice may be provided to the claimant orally within the required time frame provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

Pre-Service Claims. Guardian will provide a benefit determination not later than 15 days after receipt of a pre-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 5 days after receipt of the claim. A notification of a failure to follow proper procedures for pre-service claims may be oral, unless a written notification is requested by the claimant.

The time period for providing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 15-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Post-Service Claims. Guardian will provide a benefit determination not later than 30 days after receipt of a post- service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim.

The time period for completing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 30-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Concurrent Care Decisions. A reduction or termination of an approved ongoing course of treatment (other than by plan amendment or termination) will be regarded as an adverse benefit determination. This is true whether the treatment is to be provided (a) over a period of time; (b) for a certain number of treatments; or (c) without a finite end date. Guardian will notify a claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal.

In the case of a request by a claimant to extend an ongoing course of treatment involving urgent care, Guardian will make a benefit determination as soon as possible but no later than 24 hours after receipt of the claim.

Adverse Benefit Determination

If a claim is denied, Guardian will provide a notice that will set forth:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- in the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request; and
- in the case of an urgent care adverse determination, a description of the expedited review process.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal.

A request for an appeal of an adverse benefit determination involving an urgent care claim may be submitted orally or in writing. Necessary information and communication regarding an urgent care claim may be sent to Guardian by telephone, facsimile or similar expeditious manner.

Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- the opportunity to submit written comments, documents, records and other information relating to the claim;
- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision regarding review of an appeal as follows:

Disability Benefits

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

Group Health Benefits

Urgent Care Claims.Guardian will notify the claimant of its decision as soon as possible but not later than 72 hours after receipt of the request for review of the adverse determination.

Pre-Service Claims. Guardian will notify the claimant of its decision not later than 30 days after receipt of the request for review of the adverse determination.

Post-Service Claims. Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

When this *plan* ends, you may be eligible to continue your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

CGP-3 B800.0086

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com

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